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Requirements of Pharmacy Providers

Standards for Participation

In order to participate in the North Carolina Medicaid Pharmacy Program, pharmacists must abide by the rules and regulations of the program, be in compliance with Title VI of the Civil Rights Act, agree that the North Carolina Division of Medical Assistance (DMA) or its representatives may conduct audits as necessary, and accept payment for covered services as payment in full. Pharmacies must be operating under permit or license to dispense drugs issued by the appropriate state or federal authority.

Pharmacy enrollment

In order to participate in the Medicaid pharmacy program, the pharmacy must request participation from DMA by contacting:

DMA Provider Enrollment
P.O. Box 29529
Raleigh, North Carolina 27626-0529

DMA will mail enrollment documents, and the pharmacy must complete in full and return to DMA Provider Enrollment with a **copy of the pharmacy manager's license**. Completed in full specifically includes the **pharmacy address, permit number, and the tax identification number**. The **DEA number** may be filled in later if not available at the time of application. A copy of the pharmacist's current registration card from the North Carolina Board of Pharmacy may be sent as a copy of the pharmacist's license.

- **Change of address**

Include the new address and phone number as well as the old address, Medicaid provider number, and the pharmacist's signature with the notification letter required for a change in pharmacy status.

- **Change of pharmacy manager**

Attach a copy of the new pharmacy manager's license to the letter and include the old address, Medicaid provider number, and the pharmacist's signature. A copy of the pharmacist's current registration card from the North Carolina Board of Pharmacy may be sent as a copy of the pharmacist's license.

- **Changes in ownership or tax ID**

A new provider number is required for ownership changes of greater than 50 percent. The new owner must notify DMA Provider Enrollment within 30 calendar days of the effective date of the changes. The notification must be in the form of the letter required for a change in pharmacy status. The new owner must sign a new participation agreement and ECS agreement and return it for DMA to process and issue a new provider number. Any changes in Tax ID requires written notification and a copy of the W-9.

- **Closing a pharmacy**

The owner must notify DMA Provider Enrollment within 30 calendar days of the effective date of the closing of the pharmacy. The notification must be in the form of the letter required for a change in pharmacy status.

Changes in pharmacy status

All notifications of pharmacy changes must comply with the following criteria:

1. Notification must be on pharmacy letterhead
2. Include the pharmacy's Medicaid provider number
3. Be signed by the pharmacist

Mail notification to:

DMA Provider Enrollment
P.O. Box 29529
Raleigh, North Carolina 27626-0529

Enrolled pharmacies must notify DMA Provider Enrollment of changes in pharmacy status.

HMO Coverage in Mecklenburg or some Other Counties

DMA has contracts with HMOs to provide health care for enrolled Medicaid recipients in some counties.

Medicaid HMO enrollees outside Mecklenburg County may not receive non-emergency medical care outside the HMO (this provision excludes dental care and family planning services). HMO enrollees have Medicaid cards with the name of their HMO printed across the top (see ① on the sample card on the next page). The EDS claims processing system edits and denies claims submitted for services to clients enrolled in the HMO outside Mecklenburg County.

HMO enrollees in most counties except Mecklenburg County must obtain pharmacy services in accordance with their HMOs policies, and reimbursement will be provided by the enrollee's HMO. In these cases, claims submitted to EDS for these HMO enrollees will be denied using denial code 179.

If you have a question regarding the EDS denial (code 179) of a submitted claim that raises questions of accuracy of a recipient's Medicaid card, submit the following information to DMA for review:

- Copy of the claim
- EDS denial (remittance and status report)
- Copy of the Medicaid card
- Cover letter briefly stating problem

Mecklenburg County Managed Care Pharmacy Claims Can Be Billed by Community Pharmacies

Any Medicaid pharmacy provider in Mecklenburg County can bill for Medicaid recipients enrolled in the following plans:

Atlantic Health Plans	Maxicare
C.W. Williams (a Federally Qualified Health Center)	Optimum Choice
Kaiser Permanente	The Wellness Plan

Any Mecklenburg County Medicaid recipient who presents a Medicaid card with any of the five HMO names or C.W. William's printed on it is eligible for service by any Medicaid pharmacy provider. **This does not apply to Medicaid recipients enrolled in HMO's in Durham, Orange, or Wake counties**, only to Mecklenburg County.

The Medicaid Managed Care program in Mecklenburg County started July 1, 1996. Recipients who receive Aid to Families with Dependent Children (AFDC), Family and Children's Medicaid, or Medicaid for Pregnant women are being transitioned gradually from traditional fee-for-service Medicaid to enrollment into a managed care program called Health Care Connection. Recipients in these eligibility categories are required to choose one of the plans listed above.

Prior to July 1, 1996, recipients who were members with Kaiser in Mecklenburg County received their medications through Kaiser. At that time pharmacy services were in-plan-benefits. The HMOs are required to offer a package of "covered-in-full" services. These are called "in-plan benefits." "Out-of-Plan" benefits are services that are not part of the HMO package and will continue to be reimbursed on a fee-for-service basis. As of July 1, 1996, pharmacy services for Mecklenburg county recipients in HMOs and C.W. Williams are out-of-plan and should be billed to the State Medicaid pharmacy program, not the HMOs, on a fee-for-service basis.

These items should be submitted to:

HMO Coordinator
Division of Medical Assistance
1985 Umstead Drive
P.O. Box 29529
Raleigh, North Carolina 27626-0529

Availability

Covered pharmacy services are available to all Medicaid recipients. See the Eligibility section in Medicaid General Information for details.

Pharmacist's Responsibility

The North Carolina Division of Medical Assistance solicits the help of each pharmacist in keeping the program free of fraud and abuse. There are no limitations on dollar amount, but there is a quantity limitation of a maximum of 100 days supply. Utilization review procedures have been established for program control. It is hoped that through the cooperation of pharmacies and good utilization review procedures, further limitations in the system may be avoided.

Pharmacists must follow the North Carolina Board of Pharmacy regulations for returned medications. If a returned medication is returned to stock, **a credit must** be issued for that prescription. Credits should be handled by completing one of the following:

1. Pharmacy Adjustment Request form
2. Medicaid credit form
3. Reversal of a Point Of Sale (POS) claim

Pharmacists employed by the Division of Medical Assistance and EDS are available to assist in problems relating to coverage and billing for pharmacy services.

Pharmacy Adjustment Request Form

A Pharmacy Adjustment Request Form is used to request adjustment to a Medicaid payment. Medicaid denials with no payment can be rebilled instead of Adjusted. Examples of when to use the Pharmacy Adjustment Request Form are:

- Overriding MAC payment when "Dispense As Written" or "Brand Medically Necessary" is properly documented
- Correcting an erroneous quantity for a paid prescription
- Correcting the NDC for an erroneously billed prescription
- Crediting Medicaid for a billed and paid prescription that was never dispensed unless the credit is reported on the Medicaid Credit Report or unless a POS claim is reversed
- Crediting Medicaid for a billed and paid prescription for Unit-dose drugs that were unused
- Correcting Pharmacy of Record denials when submitted with copy of Medicaid card stub

Pharmacy Adjustment Request Forms may be obtained from Provider Services by doing one of the following:

- Calling (919) 851-8888 or 1(800) 688-6696
- Faxing request to (919) 851-4014
- Mailing request to: Provider Services
EDS
4905 Waters Edge Drive
Raleigh, NC 27606

Key to using the Pharmacy Adjustment Request Form:

Only one recipient per form with up to 4 adjusted claims for the recipient.

Recipient Medicaid Number - The 10 character recipient identification number on the card consisting of nine numeric characters with an alpha letter as the 10th character

Recipient's Name - Recipient's name on the card with the last name entered first, followed by the first name, with the middle initial last

Pharmacy Name - Pharmacy Name

Pharmacy Number - Medicaid pharmacy provider number

Four Adjustment Details consisting of the paid claim information exactly how it appears on the Remittance Advice:

Rx Number - Prescription Number assigned by pharmacy of claim to be adjusted

Drug Name - Name of the drug dispensed with the Strength and dosage form abbreviation

NDC - 11 digit NDC number

Quantity - Up to five digits for correct quantity to be billed

Billed Amt. - Correct amount to be billed for the prescription claim

Date Filled - Numeric month day and last two digit of the year

Claim Number - The ICN (Internal Control Number) of the previous paid or denied claim

Pharmacy of Record - Check here to indicate the adjustment is due to proof of Pharmacy of Record documented with copy of "stub" to override 985 denial for exceeding prescription limit

Ins. Paid - Check here to indicate correction of omission of Other Payor Amount. The "Adjustment Reason" should be used with documentation of Other Payor Amount

Pay Error - Check here to indicate keying error of manual claim form or inaccurate NDC needing validation

Incorrect Provider - Check here to indicate wrong provider number was entered on claim to be adjusted

Denied - Check here only if denied for 985 Exceeding Prescription Limitation. Other Denials should be submitted as new claims.

EOB Code if Denied - Use only if denied for 985 Exceeding Prescription Limitation

Paid Amount - Fill in the amount of the last Medicaid payment for the claim for the claim number indicated

Adjustment Reason - Describe the needed changes to the original documented above and the reason why

POS Reversals

Medicaid claims submitted using POS may be credited with a POS reversal for up to 6 months after the dispense date. It is recommended that POS Medicaid claims not dispensed be reversed weekly or, at a minimum, monthly. Pharmacies may get instruction, if needed, from their pharmacy software vendor on how to do reversals. EDS cannot reverse POS claims.

POS reversals may be sent for claims sent with incorrect quantities or NDCs. POS reversals also allow the pharmacist to help recipients who need additional medication when they have already received the maximum number of prescriptions by permitting the reversal of a less expensive prescription in order to allow billing of a more expensive prescription.

Medicaid Credit Balance Reporting:

Pharmacy providers of health care services participating in the Medicaid program are requested to submit a **Quarterly Medicaid Credit Balance Report** (copy attached for your reproduction). The Division of Medical Assistance (DMA) does not furnish copies of this form.

This report must include all OUTSTANDING Medicaid credit balances reflected in your accounting records as of the last day of each calendar quarter.

The report is to be sent to DMA no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31). **A report is required even if a zero ($0.00) credit balance exists.**

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" due the Medicaid program. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors or recipients not picking up prescriptions. For example, if a provider is paid twice for the same services (e.g., by Medicaid and another insurer), a refund must be made to Medicaid.

For the purpose of completing the report, a Medicaid credit balance is an amount determined to be refundable to the Medicaid program. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit." However, Medicaid credit balances include money due the program regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period, e.g., 90 days, and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider is responsible for identifying and repaying all of the monies due the Medicaid program.

The detail form requires specific information on each credit balance on a claim-by-claim basis. The detail form provides space for 15 claims but it may be reproduced as many times as necessary to accommodate all of the credit balances that are to be reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submit the completed Medicaid Credit Balance Report and any refunds due or recoupment requests directly to EDS as you normally do with all necessary documentation to process the refund or recoupment to the address below:

EDS
PO Box 300011
Raleigh, NC 27622

DO NOT send pharmacy refunds or recoupment requests from Quarterly Medicaid Credit Balance Reports to DMA.

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in the withholding of Medicaid payments until the report is received.

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____CONTACT PERSON:_____

QUARTER ENDING: _____TELEPHONE NUMBER: (__)_____

(1) PROVIDER NUMBER	(2) RECIPIENT NAME	(3) MEDICAID ID NUMBER	(4) RX NUMBER	(5) MEDICAID ICN	(6) DATE DISPENSED	(7) DATE PAID	(8) CREDIT AMOUNT
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.	(See back of form for instructions)						

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, subtotal the credit amount for each provider number. Total the amount for all providers.
- The month and year of the reporting quarter, e.g., September 1996
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1- Provider Number

Column 2- The last name and first initial of the Medicaid recipient (e.g., Doe, J.)

Column 3- The individual Medicaid identification (MID) number

Column 4- The prescription number

Column 5- The Medicaid ICN (claim) number

Column 6- The month, day, and year of service (e.g., 12/10/95)

Column 7- The R/A date of Medicaid payment (not your posting date)

Column 8- The amount of the credit balance. Subtotal the credit balances for each provider and total for all providers.

Mail the credit balance report with a check within 30 calendar days of the end for each calendar quarter.

Recipient lock-in to one pharmacy/month

DMA has implemented a Recipient Lock-In (Restricted Pharmacy Services) Program. Recipients are restricted to a single pharmacy each month except for emergencies.

Instructions for pharmacists on handling cards

If the recipient brings in a new Medicaid Identification (MID) card with the tab attached:

1. Remove the tab designated to monitor pharmacy services. Retain this tab on file as proof of "Pharmacy of Record." The second date or thru date on the tab indicates the month for determining "Pharmacy of Record." For example, if the thru date is 03-31-96, then the holder of this tab is the "Pharmacy of Record" for the month of March 1996.

2. Stamp the pharmacy name, address, and telephone number on the MID card which is returned to the recipient. This information is for any other pharmacist who may be requested to fill prescriptions during the month.

3. Keep a record for each recipient of the date of service for each prescription dispensed.

4. Bill Medicaid for up to the legislative limit of prescriptions.

If the recipient brings a MID card without the pharmacy of record tab:

1. Call the pharmacy whose name appears on the card to determine whether all allowed prescriptions have been filled

2. If prescriptions will be filled, ask the pharmacist who holds the tab for permission to fill a specified number of prescriptions and the date the prescriptions for the recipient will be filled

3. Bill Medicaid for the prescriptions dispensed

Note: Medicaid will only pay for six prescriptions per month per recipient. If a denial for exceeding the limit occurs, reimbursement may be recouped from any pharmacy who did not retain the tab as proof of "Pharmacy of Record." For more information see the "Pharmacy of Record" section.

If more than the legislative limit of prescriptions are filled during a month, Medicaid will honor the claims of the "Pharmacy of Record" first. For example, if the pharmacist holding the "Pharmacy of Record" tab has claims denied because the recipient shopped elsewhere and exceeded the legislative limit, the pharmacist can complete a Pharmacy Adjustment Request and file with:

1. A copy of the tab
2. A copy of the claim
3. A copy of the RA indicating the denial

The excess payments made to the provider without the tab will be recouped and the claims from the "Pharmacy of Record" will be resubmitted for payment.

Filing Prescriptions

All pharmacy providers are required by their Provider Agreement in C - 4 that "as a provider of pharmacy services, the provider certifies and agrees to file prescriptions numerically and in chronological order, either in normally occurring order with other prescriptions filled by the provider or in a separate file and to record each authorized refill." Program Integrity auditors are finding that some providers are not in compliance. Failure to comply is a direct violation of a provider's Medicaid Provider Agreement. There are no exceptions.

Method of Updating the Pharmacy Manual

The Pharmacy Medicaid Manual is amended or enhanced by the periodic publication of the Pharmacy Medicaid Newsletter. These newsletters should be updated into the pharmacy manual and retained for future references. Please check the front of the Remittance Advice (RA) for banner messages containing important information that is necessary to be distributed quicker than a Pharmacy Medicaid Bulletin can be published.

Scope of Services

Criteria for coverage

Medicaid coverage of pharmacy services consists of payment for certain Federal Legend drugs and insulin when dispensed by a participating pharmacy.

Covered services

All drugs which bear the Federal Legend statement and have Federal Drug Administration (FDA) approved indications with the exceptions of Noncovered Items are covered by the North Carolina Medicaid Pharmacy Program. Coverage of compounded prescriptions are addressed in another section entitled "Compounded Drugs."

Noncovered items

The following is a list of services not covered by Medicaid when billed under the pharmacy program.

1. Over the counter drugs (except insulin)
2. Federal Legend drugs or their generic equivalents which are on the Drug Efficacy Study Implementation (DESI) list established by the FDA
3. Any drug manufactured by a company who has not signed a rebate agreement
4. Medical supplies or devices: needles, syringes, catheters, I.V. sets, T.E.D. hose, etc.
5. Diaphragms
6. Routine immunizations, flu vaccine, DPT immunization, etc.
7. Fertility and impotence drugs
8. Drugs used for cosmetic indications
9. Durable medical equipment: oxygen concentrators, wheelchairs, etc.

Medicaid drug rebate program

Effective April 1, 1991, the pharmacy program can only cover drugs from manufacturers who have signed national Medicaid Drug Rebate Agreements with the Health Care Finance Administration (HCFA). Drug companies sign the agreements for specific drug manufacturer codes. Drug coverage is thus determined by the manufacturer code and not by the manufacturer name. The manufacturer code is indicated by the first five digits of the 11-digit NDC (National Drug Code) number. Since rebates are determined by State Medicaid utilization data, it is imperative that pharmacies bill Medicaid the NDC number of the drug actually dispensed. If accurate NDCs are not used for pharmacy claims, there is the potential for denial of claims, sanctions, and termination of provider agreements. North Carolina Medicaid will supply pharmacy providers with a list of covered Medicaid Rebate Manufacturers through Medicaid Pharmacy Newsletters. Updates and corrections will appear via newsletters or RA banner messages.

Prior approval

The pharmacy program does not require prior approval.

Medicaid Policy for Pharmacy

Dispensing Limitation and Exemptions

The NC General Assembly has established a limitation of **SIX PRESCRIPTIONS** per recipient per month to be covered by the pharmacy program. Some prescribers may elect to write some prescriptions for more than a month's supply for those recipients who exceed their six prescription limit due to the number of recurring medications they must take for chronic conditions. This is an acceptable practice as long as it is monitored and managed by the prescriber.

- **Exemptions from the Prescription Limitation**

A. Exemption from this limitation was authorized by the Department of Health and Human Services "when the life of the patient would be threatened without additional care." Therefore, patients being treated for one of the following conditions are exempt from the prescription limitation. To indicate exemption, the six prescription override form must be signed and checked by the physician with the appropriate diagnosis indicated, and kept on file in the pharmacy at all times. The diagnoses allowing exemption are listed below. This form must be updated every 6 months and readily retrievable in case of an audit. Only one form is required per recipient and must be signed by any of the primary physicians for that recipient. The pharmacy is at risk for recoupments if these requirements are not met. A copy of this form can be found on the following page. This is the only accepted form, and it may be reproduced.

The diagnoses allowing exemption from the prescription limitation when documented in the prescriber's own handwriting are:

1. End-stage renal disease
2. Chemotherapy and radiation therapy for malignancy
3. Acute sickle cell disease
4. Hemophilia
5. End-stage lung disease
6. Unstable diabetes
7. Terminal stage - any illness, or life-threatening - any illness

The Six Prescription Limit Override Form can be found on the following page.

NORTH CAROLINA
MEDICAID PHARMACY PROGRAM

Six Prescription Limit Override Form

North Carolina Medicaid Recipients are allowed only six prescriptions per month unless they have one of the diagnoses below. If the attending physician determines that a recipient is eligible for the override, he/she must check all diagnoses that apply, complete the rest of the form and sign in his own handwriting.

- [] Acute Sickle Cell Disease
- [] Hemophilia
- [] End Stage Lung Disease
- [] End Stage Renal Disease
- [] Unstable Diabetes
- [] Chemotherapy or Radiation Therapy for Malignancy
- [] Any Life Threatening Illness or Terminal Stage of Any Illness

Recipient's Name _____

Recipient's MID Number _____

Facility _____
(Fill out only if in nursing facility or adult care home)

Physician's Signature _____

Date _____

* THIS FORM MUST BE UPDATED EVERY SIX MONTHS IF THE RECIPIENT STILL QUALIFIES FOR THE SIX PRESCRIPTION OVERRIDE

* THIS IS THE ONLY ACCEPTED FORM AND MUST BE KEPT ON FILE IN THE PHARMACY AT ALL TIMES

THIS FORM MAY BE REPRODUCED

DMA 3098

B. Recipients who are participating in the Community Alternatives Program (**CAP**) are exempt from the prescription limitation and the copay requirements. The prescriber and pharmacist do not need to indicate this exemption on the prescription because CAP status is on Medicaid eligibility file. The pharmacist should check the Medicaid ID card for the CAP indicator. If there is a two-letter code in the CAP block on the card, the recipient is participating in a CAP program. The CAP block is at the top, left of the card.

CAP BLOCK	PROGRAM
CI or CS	Community Alternatives Program for Disabled Adults (CAP/DA)
CM	Community Alternatives Program for Mentally Retarded/Developmentally Disabled (CAP-MR/DD)
CC	Community Alternatives Program for Children (CAP/C)

C. Recipients who are less than 21 years of age are exempt from the prescription limitation under guidelines established through the Healthy Children and Teens Program. The prescriber does not need to indicate this exemption on the prescription since it is incorporated in the eligibility files.

- **Indicating exemption from the prescription limitation**

When submitting a claim, the exemption from the prescription limitation is indicated by placing an "E" in the block used to designate patient location (LOC) on the claim or placing 5 in the Prior Auth Indicator on a POS claim. Failure to use the indicator could result in denial as exceeding the legislative prescription per month limitation. It is not necessary to use the "E" for CAP and recipients under 21. These recipients are still subject to the pharmacy lock-in requirements.

Copay

All eligible Medicaid recipients who receive pharmacy services are required to pay a co-payment of $1.00 for each prescription received unless they are exempt for one of the following reasons.

- **Reasons for exemption from copay**

1. The recipient is under 21 years of age.

2. The recipient resides in a nursing facility, intermediate care facility - mental residence, or a mental hospital (adult care homes and hospice patients are responsible for co-payment).

3. The recipient is pregnant. For a pregnant recipient, it is requested that the prescriber note Pregnancy on the prescription. A "P" must be in the Location Field or a 4 in the Prior Auth Indicator on a POS claim to indicate exemption from the co-payment deduction for Pregnancy.

4. The drug is classified as Family Planning (birth control pills). Exemption from the copay for Family Planning drugs is indicated on the drug file and does not require use of a "X" in the FP field. Do not collect a copay for oral contraceptives.

5. The recipient is classified as a Community Alternatives Program (CAP) recipient as indicated on the Medicaid identification (MID) card.

- **Indicating exemption from the copay on claims**

If a recipient qualifies for exemption from the copay because the recipient is a resident of a nursing facility, the pharmacist is required to indicate the exemption due to location (#2 above). Location is indicated as follows:

Location	NCPDP POS Location	Paper, tape, modem, and diskette claims
Intermediate Care Facility - MR	2	7
Nursing Facility	7	8
***Exempt from both copay and 6 Rx limit*	8	B

Pregnant recipients must have a "P" in the Location Field or a 4 in the Prior Auth Indicator on a POS claim to indicate exemption from the co-payment deduction for pregnancy.

The pharmacist does not have to enter an indicator for exemption from copay because it is documented in the Medicaid files instead of on the claim for:

1. Recipients under 21 years of age
2. Family Planning Drugs
3. CAP recipients

100 Days Supply Maximum for Medicaid prescriptions

North Carolina Medicaid will reject prescriptions for more than a 100 days supply. This limitation will be based on Days Supply submitted and the maximum daily quantity for each NDC from a national source. The system will edit against days supply entered by the pharmacist and the maximum units per day of a particular drug. The system will not allow a drug to be dispensed for 400 units if the maximum units per day is 2. Please use the 100 days supply maximum for Medicaid prescriptions.

Do Not Reduce Prescription Quantities

The Pharmacy Program Participation Agreement states "The provider agrees to supply Federal prescription legend drugs, insulin and other drugs covered by the Program in the amount and kind prescribed." There is no mention of reducing unreasonable amounts without obtaining a new prescription. The only allowed reduction would be a reduction to a 100 days supply maximum if the prescription is for more than a 100 days supply. Medicaid audits have found a significant amount of quantity splitting on prescriptions.

Splitting quantities generates extra dispensing fees which are subject to recoupment.

Method of Handling "IOU" When Partial Fill is Done

Program Integrity's auditors are finding "IOUs" being given to recipients when the pharmacy is unable to deliver the full amount of a prescription at the time the patient is present. However, Medicaid is being billed for the total quantity of drug prescribed. Medicaid does not pay for medication not received by the recipient. If the recipient does not pick up the amount of medication the prescription was originally written for or the remaining amount owed is never dispensed or credited to the Medicaid program, it will be considered as a potentially fraudulent practice and the appropriate action will be taken. Please refer to pages 4 and 5 for instructions on how to issue credit for any prescription or portion thereof which is not claimed by the recipient.

Incorrect Units for "Unbreakable" Packages May Be Denied

Billing inaccurate package sizes creates extra costs and delays for the Medicaid program collecting drug rebates from manufacturers. Frequently the quantity billed for drops does not match the package size, e.g. 5 mls is billed for the 10 ml NDC. Bill the quantity that matches the package size for the NDC billed. If a different package size is used for the refill, you should update the prescription to have the drug dispensed match the drug on the label, as is required by law.

On April 1, 1995, North Carolina Medicaid adopted the national standard "round up" policy for billing package sizes with decimal point quantities and published notification of this policy in the March 1995 Medicaid Pharmacy Newsletter. Many providers have not changed their billing to utilize the standard units. For Medicaid billing round up the number of units for a package with a decimal point pack size, e.g. 8.2 should be billed as 9. The following drugs are some of the drugs being frequently misbilled. Please check and change, if necessary, the package size for the drugs below in your billing to prevent denied claims in the future.

Examples

Drug	NDC	Billing Units	Package Size
Beclovent Inhaler	00173031298	17	16.8
Estrace 0.01% Cream w Applic.	00087075442	43	42.5
Intal Metered Sprays	00585067501	15	14.2
Novolin 70/30 100U Cartridge	00169183717	2	1.5
Premarin Vaginal Cream W Appl	00046087293	43	42.5
Stadol NS 10mg/ml Spray	00087565041	3	2.5

Generic Substitution and MAC Overrides

Generic Substitution

The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescribers personally indicates in his/her own handwriting on the prescription order, "Brand Medically Necessary" or "Dispense as Written."

The selection of a drug product shall not be more expensive than the brand or trade name originally written by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner. For audit purposes, the brand name and manufacturer must be documented on the prescription.

Maximum allowable cost (MAC) Overrides

The North Carolina Pharmacy Program has been mandated by Federal regulations to implement a Maximum Allowable Cost (MAC) for some multiple source drugs. It is possible to override the MAC limitations if a prescriber certifies that a specific brand of drug which has a MAC limitation is medically necessary for a particular recipient. This certification must fall under Federal regulations which specify that the certification **"Dispense as Written" or "Brand Medically Necessary" must be in the prescriber's own handwriting** and signed by the prescriber. This can be written directly on the face of the prescription or on a separate document which must be attached to the original prescription.

The procedure for billing MAC overrides depends on the claim submission method. 0A (numeric zero, alpha A) are the last two digits of the NDC for a MAC override on a paper or ECS claim. 0A should not be used when billing brand name, single source drugs. Dispense As Written (DAW) 1 on a POS claim is a MAC override.

The following are not acceptable for drugs with MAC prices:

- The prescriber is not allowed to indicate "Dispense As Written" or "Brand Medically Necessary" over the telephone for the pharmacist to document on the prescription if the drug is a MAC drug. (If the drug is <u>not</u> a MAC drug, the pharmacist may receive oral authorization not to substitute from the prescriber, write "Dispense As Written" on the prescription, and initial it. If a telephone prescription requiring Brand only is accepted, the prescriber must send a new prescription within 72 hours with "Dispense As Written" or "Brand Medically Necessary" written on the prescription in the prescriber's own handwriting.)
- A prescriber's signature over a printed statement indicating "Dispense As Written" or "Brand Medically Necessary" with a check or X in a box on the prescription indicating "Dispense As Written" is unacceptable
- A handwritten statement transferred to a rubber stamp and then stamped on the prescription is unacceptable
- The abbreviation "DAW" on the prescription by the prescriber is unacceptable

If a physician has properly authorized for the dispensing of a brand name drug product when that drug product is a MAC drug, the pharmacist can bill Medicaid for reimbursement based on the lower of the usual and customary charge or the Medicaid reimbursement rate of the brand name drug plus the dispensing fee. To indicate that the prescriber has documented "Brand Medically Necessary" and **bill for the brand, the last two digits of the NDC should be billed as 0A (numberic zero, alpha A) for paper or ECS (Electronic Claims Submission) or with Dispense As Written (DAW) 1 on an on-line POS claim. Do not use 0A for brand name, single source drugs. The MAC override should only be used to override a MAC price.**

DESI drugs

Reimbursement is denied on drugs described by the FDA as DESI. These are products which the FDA has found to be less than effective or not proven to be effective as indicated. Drug products which are identical, related, or similar to DESI drugs are also DESI. Updates and corrections will appear via newsletters or RA banner messages and are available from drug pricing file service providers.

Compounded drugs

- **Definition of a compounded drug**

A compounded prescription is defined as a mixture of two or more ingredients that are physically inseparable. Each compounded prescription must contain at least one legend drug in order to be reimbursed by Medicaid.

A compounded prescription must contain a quantity of a legend drug sufficient to have a therapeutic effect. It cannot be two different drugs (capsules and/or tablets) separable but dispensed in the same bottle. All DESI drugs and combinations equivalent to a DESI drug are not reimbursable in compounded prescriptions.

Example: Guaifenesin and Theophylline is equal to Quibron, which is DESI and noncovered.

A compounded prescription which is equivalent to an over-the-counter (OTC) drug is not reimbursable.

Example: Hydrocortisone 1% cream 60gm and Eucerin Cream 60 gm is equal to Hydrocortisone 0.5% cream 120 gm, which is OTC and noncovered.

- **Billing compounded drugs**

All compounded prescriptions must be submitted on a **paper pharmacy claim form with NDC 00990-0000-00**, not the major ingredient's NDC. Use of the major ingredient's NDC frequently results in fraudulent overbilling and in inaccurate reporting for federally mandated Drug Rebate reports. Compounded prescriptions can not be billed electronically because all the ingredients can not be included in the electronic billing record. **Electronically billed claims for 00990-0000-00 will be rejected** with EOB 074 which states "Rebill for services on a paper claims."

To indicate a compounded prescription, place the code 00990-0000-00 in the NDC field on the pharmacy claim form. Fill in the rest of the fields as required for all manual claims. At the bottom of the claim form **list the drug name, strength, quantity, NDC number, manufacturer, and the cost of each ingredient** contained in the compound. Failure to give the NDC number for each Federal Legend product contained in the compound will result in a denial with EOB 005 which states "NDC # missing or invalid." Failure to list any ingredients or to list quantities will result in a denial with EOB 900 "Claim denied for lack of requested information."

- **Billing multiple compounds for the same recipient**

If two different compounded prescriptions are dispensed within the same calendar month for the same recipient, bill the second compounded prescription with NDC code 00990-1000-00 in the NDC field on the pharmacy claim form. Failure to list this code will result in a duplicate denial with the first compounded prescription. If a third compounded prescription is necessary, the code would be 00990-2000-00, and so on increasing the digit in the sixth position as needed. If more than one compounded prescription has been dispensed, file the additional compound(s) on a separate claim form if all ingredients can not be described in the space provided in the ingredients field.

- **Reimbursement for compound drugs**

Medicaid will reimburse only for federal legend drugs contained in the compound that are manufactured by companies who have signed a national Medicaid Drug Rebate Agreement with HCFA. If one prescription drug in the compound is not covered under the rebate agreement, reimbursement will be withheld for that drug only. The remainder of the compound will be paid if applicable. OTC products are reimbursed when included in a compound with at least one covered legend drug.

- **Summary of compound drug reimbursement**

Reimbursable compounds:

- Mixture of two or more physically inseparable ingredients, with at least one legend ingredient
- Only legend drugs from manufacturers who signed the Drug Rebate Agreement will be reimbursed

Non-reimbursable compounds:

EOB	Requirement not met
905	A compound without a legend covered drug
905	A compound with only non-rebate drugs
038	OTC and DESI drugs as only ingredients
009	A compound equivalent to an OTC drug
009	OTC ingredients only
009	Two physically separable drugs (tablets and capsules) in the same bottle

Allergy vaccines are covered

Medicaid often receives inquiries concerning coverage of allergy vaccines. Allergy vaccines are covered as long as a copy of the invoice for the vaccine is attached to the pharmacy claim. The vaccine should be billed using the compound NDC number. Medicaid will reimburse for the cost of the drug and the dispensing fee. The shipping charges are not covered through the pharmacy program and may be billed to the recipient.

Eligibility verification through the Voice Inquiry System

EDS' automated Voice Inquiry Systems allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid Program. By dialing **1-800-723-4337** on a touch-tone phone, providers can inquire about:

- Current Claim Status
- Checkwrite Information
- Prior Approval Information
- Procedure Code Pricing
- Drug Coverage Information
- Recipient eligibility verification

The EDS Voice Inquiry System is available Monday through Friday, 8:00 a.m. to 9:00 p.m. The expanded hours of operation of our Voice Inquiry System allows us to more efficiently respond to provider requests for information. As in the past, EDS' Service Relations Analysts are available between 8:00 a.m. and 4:30 p.m. Monday - Friday to discuss concerns not addressed by the voice inquiry system.

Please refer to the following quick reference guides for accessing the North Carolina Medicaid Program Voice Inquiry System. You are encouraged to post a copy of these pages at a convenient location to facilitate information retrieval through EDS' Voice Inquiry System.

Transaction codes and information to have on hand prior to dialing:

Transaction Code	Description	Required Information
1	Claim Status	Provider number, Medicaid ID number, "From" Date of Service, total billed amount
2	Checkwrite	Provider Number
3	Drug Coverage	Provider Number, Drug Code, Date of Service
4	Procedure Code Pricing	Provider Number, Procedure Code, Type of Treatment Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code
6	Recipient Eligibility	Provider Number, Medicaid ID Number or Social Security Number and Date of Birth, "From" Date of Service
7	Pre-Admission Certification	Please call 1-800-772-6762 or 919-851-2955

Note: If you remain on the line after the system requests the transaction code, this menu will be given to you on the Voice Inquiry System.

Alphabetic data table

The following table is reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to place an asterisk (*) before the numeric codes.

A-*21	F-*33	K-*52	P-*71	U-*82
B-*22	G-*41	L-*53	Q-*01	V-*83
C-*23	H-*42	M-*61	R-*72	W-*91
D-*31	I-*43	N-*62	S-*73	X-*92
E-*32	J-*51	O-*63	T-*81	Y-*93
				Z-*02

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone key pad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key # 8, in the third position, thus 83.

Quick Keys

The following telephone key combinations will expedite your calls:

- To repeat the last response given, enter *#
- To repeat the last prompt given, enter **#
- To void data and re-enter valid data, enter ** then the correct data (for example, if 12345 is the procedure code and 123456 was entered in error, enter **12345 to make the correction.
- To abort and return to the menu selection, enter *99#
- To specify the current calendar date when prompted for From Date of Service (FDOS), enter #.

Detailed instructions for accessing eligibility information on the Voice Inquiry System (press 6)

Step 6.1

Voice inquiry will prompt you for a Medicaid provider number when inquiring on multiple provider numbers:

> "Please enter your Medicaid provider number followed by the pound sign"

Step 6.2

Once a valid provider number has been entered, the system will prompt you for a recipient ID number:

> "Please select one of the following recipient identification options followed by the pound sign. For recipient Medicaid number, press 1. For social security number, press 2."

Depending upon which option is selected, you will hear one of the following messages:

> "Please enter the recipient's Medicaid ID number followed by the pound sign"
>
> **or**
>
> "Please enter the recipient's social security number followed by the pound sign."

If you select option 2 (social security number), you will also be prompted for the recipient's date of birth:

> "Please enter the recipient's date of birth in month, day, year format, followed by the pound sign."

Step 6.3

Once a valid recipient ID number has been entered, the system will prompt you for the date of service. The date of service must be entered in MMDDYY format.

> "If today is the date of service, enter the pound sign. Otherwise please enter another date of service in month, day, year format followed by the pound sign."

Step 6.4

Once a valid date of service has been entered, you will receive one of the following messages:

> "Recipient ID is not on file, or recipient SSN is not on file. Please re-enter."
>
> **or**
>
> "Recipient ID (MID or SSN) is not eligible for Medicaid services on (date of service). You may wish to verify the date of service you entered."
>
> **or**
>
> "Recipient ID (MID or SSN), is eligible for Medicaid services on date of service."

You will also receive the following message(s) if the recipient has special coverage:

> "The recipient is covered by the Medicaid Pregnant Woman Program."
>
> **and/or**
>
> "The recipient is a Qualified Medicare Beneficiary, MQB. Medicaid can only pay for Medicare coinsurance and deductible charges."
>
> **and/or**
>
> "The recipient is enrolled in an HMO. Please ask the recipient for an HMO card."
>
> **and/or**
>
> The recipient is enrolled in Carolina ACCESS."

Step 6.5

Once recipient eligibility has been established, the system will provide information pertaining to Medicare coverage. You will receive one of the following messages:

> "The recipient has Medicare part A coverage."
>
> **or**
>
> The recipient has Medicare Part B coverage."
>
> **or**
>
> The recipient has Medicare Part A and Part B coverage."

Step 6.6

Once Medicare eligibility has been established, the system will provide information pertaining to other insurance coverage. If the recipient does not have other insurance, the system progresses to Step 6.7. If other insurance is on file, you will hear the following messages:

> The recipient has other insurance with (number of carriers) carriers."
>
> **and/or**
>
> The recipient has other insurance with (company name or company code). The insurance policy number is (policy number)."

If there are additional insurance carriers, the system continues with the following message:

> There is/are (number of carriers) carrier/carriers remaining. To hear information for the next insurance carrier, press the pound sign. To repeat the previous response, press the asterisk (*) key followed by the pound sign. Otherwise, press 1 followed by the pound sign."

Step 6.7

At this point the system has completed eligibility verification inquiry for the identified recipient. The system will prompt you with the following options:

> To verify eligibility for the same recipient with a different date of service, press 1 followed by the pound sign. To verify eligibility for a different recipient, press 2 followed by the pound sign. To return to the main menu press the pound sign. If this concludes your call, please hang up."

Billing Medicaid claims

General information

Each time Medicaid services are rendered, the provider must check the Medicaid identification (MID) card to verify that the recipient is eligible on the date the service is to be rendered. The prescription should be verified for Medicaid coverage. All claim fields, whether submitted real time (POS), electronically, tape-to-tape, or on paper via the pharmacy claim form must be completed. The pharmacist should retain a copy of the claim on file.

Directions for reimbursement

Reimbursement is determined using the cost per unit times the quantity dispensed, plus the dispensing fee. Reimbursement is limited to the applicable price in effect on the date of service, not on the date of payment.

The Medicaid provider shall bill Medicaid at the applicable Medicaid rate plus the dispensing fee or the usual and customary charge to the general public, whichever is less. For more information, see the section on Definition of repeat or refill drugs in the same month of service.

Repeats of the same prescription in the same month will be reimbursed at the lower of usual and customary price submitted, cost submitted, AWP applicable Medicaid cost minus 10%, or applicable MAC (Maximum Allowable Cost) price.

Dispensing fee

The dispensing fee, or professional fee of $5.60, is added to the cost of the drug to equal the maximum allowed "Billed Amount" for each claim. Changes in the dispensing fee amount are reported in Medicaid Pharmacy Newsletters, by special mailings, or on RA Banner Messages. The dispensing fee will automatically be deducted from each repeated drug within the same calendar month. A pharmacy billing a rate which is less than the Medicaid rate should bill the Medicaid dispensing fee on repeats or refills in the same calendar month since the Medicaid dispensing fee will be automatically deducted.

Cost of the drug

The cost of the drug will be calculated from the lower of the cost on file from First DataBank using the AWP less 10%, the MAC price if applicable, or the actual acquisition cost reported by the pharmacy. AWPs are updated weekly via magnetic tape from First DataBank. MACs are updated twice a year from HCFA.

Billing Remainder of a Third Party Prescription to Medicaid

Medicaid is always the payor of last resort when a recipient has other insurance that covers prescription drugs. If a recipient has **Other Insurance including Medicare** which pays for prescriptions, that insurance plan must be billed first. Medicaid may be billed for the unpaid portion of a claim paid by another insurance company by entering the following information in the appropriate fields on the claim form.

- The amount paid by the other insurance in Other Cov. Field
- The Medicaid reimbursement rate (lower of the Usual and Customary price or AWP - 10% + $5.60) in the Amount Billed field (dollars/cents)

Medicaid will pay the difference between the Medicaid reimbursement rate less the copayment of $1 where applicable less the amount paid by the other insurance.

Medicaid reimbursement rate
- Amount paid by other insurance
- Medicaid co-payment according to Medicaid Drug and Eligibility files
= Medicaid payment

A **Medicare** claim will be treated as any other third party crossover. The price will be calculated using the standard Medicaid reimbursement rate and the Medicare payment will be subtracted. The Medicare payment voucher should be attached to the manually submitted pharmacy claim.

If a recipient is MQB (Medicare Qualified Beneficiary) and Medicare pays, file claim as shown above and submit for manual payout to: EDS, Provider Services/Community Care, P.O. Box 300009, Raleigh, N.C. 27622. If Medicare does not pay for MQB, then no payment is due from Medicaid. Do not file a claim.

The following is a list of incorrect ways to bill a pharmacy claim for a Medicaid recipient who has prescription coverage from another insurance plan. DO NOT submit claims to Medicaid with these errors.

- Do NOT bill the full amount ($) to the other insurance and to Medicaid simultaneously. This action can be interpreted as a fraudulent billing, since the pharmacy could get double payment for one prescription claim.

- Do NOT submit a Medicaid claim showing the amount not paid by the other insurance, i.e. the other insurance copayment, as the amount billed. This action results in incorrect payments and/or denials. It also results in incorrect drug data which can be and is disputed by the manufacturers in the Drug Rebate Program, thereby costing the Medicaid Pharmacy Program revenues..

You may need to contact your pharmacy software vendor concerning getting the other payor amount onto the Medicaid claims.

Billing time limit

The Division of Medical Assistance (DMA) frequently receives requests to waive the Federally prescribed 12 month claims filing time limit. DMA has extremely limited authority to override the time limit when eligibility was not approved within the year, or for court decisions or hearings which authorizes eligibility retroactively. Failure of the provider to file and follow up timely is not a basis for override and will result in denial of claims.

Medicaid claims other than crossover and third party must be received by EDS within 365 days from the date of service. Hospital inpatient, long term care, and home health claims must be received within 365 days from the last date of service on the claim. Medicare-Medicaid crossover and other third party claims must be received within 180 days from the date of payment or denial from the third party payor, or 365 days from the date of service, whichever is later. Proof that the claim was submitted timely includes:

- Correspondence about the claim received from NC Division of Medical Assistance or EDS
- An explanation of Medicare or third party benefits dated 180 days from the date of payment or denial
- A copy of the remittance advice (RA) showing the claim pending or denied

  It is the provider's responsibility to file claims timely and follow up within the time limit for claims not reported back on the RA. When claims are initially filed, providers should allow approximately 30 days for the transactions to appear on the remittance report. If there is not indication on the RA that the claim was received, providers may use the EDS Voice Inquiry System to determine the status of the claim.. If the claim has not been received by EDS, providers should resubmit immediately to prevent denial for timely filing.

National Drug Code (NDC)

The national drug code (NDC) is an arrangement of eleven characters used to identify a drug product and package size manufactured or distributed by a specific manufacturer. It is comprised of three "fields" of data as follows:

AAAAABBBBCC	Drug Code Structure
5 4 2	Number of digits in each field
AAAAA	The Manufacturer
5	
BBBB	The Drug Product
4	
CC	The Package Size
2	

Leading zeros must be used for proper placement of numbers or letters in the NDC number field of the pharmacy claim form or pharmacy software for ECS billing. Failure to record all 11 digits in the proper position may result in a claim denial.

Example: Inderal 20 mg Tablet 0046 422 81 should be spaced - 0 0 0 4 6 0 4 2 2 8 1

Defining the drug units

All quantities should be submitted in metric units. If the quantity is a decimal, round up to the nearest whole number, e.g., 2.5 ml Stadol = 3 ml. The following rules and examples apply:

1. **Tablets, capsules, and suppositories**: The unit is "one" or "each." For example, if 10 tablets are dispensed, the quantity is 10.

2. **Ointments, creams, balms, and bulk powders**: The units is "gram." For example, if a 15 gram tube of ointment is dispensed, the quantity is 15.

3. **Liquids, suspensions, solutions, large volume IV solutions, and irrigations**: The unit is "ml." For example, if a 4 ounce bottle of liquid is dispensed, the quantity is 120.

4. **Injectable items**:

    a. If the product is **in solution**, the unit is "ml" and the quantity is the volume size. For example, if a 100 ml bag of Sodium Chloride is dispensed, the quantity is 100.

    b. If the product is a **partial-fill**, the unit is "ml" and the quantity is the amount of fill volume containing the actual drug. For example, if Dextrose 5% 250 ml in a 500 ml bottle is dispensed, the quantity is 250.

    c. If the product is a **powder filled vial for reconstitution before injection**, the unit is "one" or "each." For example, if a vial of injectable Ampicillin has to be reconstituted into solution by the pharmacist, the quantity is 1. Note that when a product comes with a separate vial or ampule or diluent it is still treated as a powder for reconstitution under this policy.

5. **Packets**: The unit is "one" or "each" regardless of whether the packet is labeled with the weight or not. For example, if 10 packets of Questran are dispensed, the quantity is 10.

6. **Disposable enemas**: If the individual enema is labeled by volume, the unit is "ml" and the quantity dispensed is the number of milliliters in the enema container. If the individual enema is not labeled by volume, the unit is "one" or "each" and the quantity is 1 for each enema.

7. **Aerosols, jellies, and gels**: If the product is labeled in weight, the unit is "gram." For example, if an aerosol is dispensed as 16.8 grams, the quantity is 17. Similarly, if the product is labeled in volume, the unit is "ml." If the product is not labeled by weight or volume, the unit is "one" or "each".

8. **Reconstituted non-injectable liquid dosage forms**: For antibiotic oral suspensions, eye drops, and other non-injectable forms that require reconstitution prior to dispensing and that are labeled by volume, the unit is "ml." For example, if a 150 ml Amoxicillin Oral Suspension is dispensed, the quantity is 150.

9. **Granulex Spray**: The units is "ml." For example, if a 4 ounce can is dispensed, the quantity is 120.

10. **Antihemophilic factor (AHF) products**: The unit is "one" which equals one Internation Unit (IU) of AHF. For example, if 1000 IU of AHF is dispensed, the quantity is 1000.

11. **Combination packages**: For drug products that contain more than one drug in separate dosage forms and that are packaged and dispensed in an "unbreakable" container, the unit is "one" or "each."

12. **Metric package sizes**: The quantity or total number of units is always the actual metric package size as supplied by the manufacturer/distributor. If the actual metric package is unavailable, the following conversions are used:

    1 fluid ounce = 30 ml
    1 pint = 480 ml
    1 ounce = 30 gm
    1 pound = 454 gm

Definition of repeat or refill drugs in the same month of service

The pharmacy program mandates that a dispensing fee, or **professional fee, shall not be paid for repeats or refills** of the same drug twice within the same calendar month; nor shall two prescriptions for the same drug be billed on the same day. The following defines what constitutes the same or different drug in the same month of service.

1. A drug in which the active portion is different and is not generically equivalent to any other drug dispensed to the same recipient in the same calendar month shall be considered a different drug.

   Example: Tetracycline
   Pilocarpine — 3 different drugs
   Meprobamate

2. A different dosage form (liquid, tablet, suppository, injection, etc.) of the same drug will constitute a different drug.

   Example: Phenergan Tablets — 2 different drugs
   Phenergan Suppositories

3. A different strength of the same drug will constitute a different drug.

   Example: Mellaril 10 mg — 2 different drugs
   Mellaril 50 mg

4. A different chemical form of the same basic drug will not constitute a different drug if the dosage form and strength is the same.

   Example: Tetracycline Hydrochloride — 1 drug only
   Tetracycline Metaphosphate Buffered

5. A generic equivalent by different trade name will not constitute a different drug.

   Example: Tetracycline by Geneva
   Tetracycline by Rugby — 1 drug only
   Achromycin

Procedure for billing exemptions from the six prescription limit

If a recipient qualifies for one of the three types of exemptions from the six prescription limit, the pharmacist is allowed to bill Medicaid for more than six prescriptions per month. To indicate that the recipient is exempt, place an "**E**" **in the location field** on the Pharmacy Claim Form and in the location field on the pharmacy billing record if submitting electronically or a Prior Authorization Medical Code (PA/MC) value of 5 for Point Of Sale real-time claims. A "B" code should be used in the location field if submitting electronically for recipients exempt from **both** copay and 6 prescription limit or a (PA/MC) value of 8 for POS claims. See the section on Six Prescription per month limitation for more complete information.

Procedure for billing an override on MAC drugs

If a prescriber has properly authorized the dispensing of a brand name drug product when that drug product is a MAC drug, the pharmacist can bill Medicaid for reimbursement based on the applicable Medicaid reimbursement rate of the brand name drug. To indicate that the prescriber has documented "Dispense as Written" place a "0A" (zero, A) in the place of the last two digits of the NDC code for paper and ECS claims or place a "1" in the DAW field for Point of Sale real-time claims. 0A should only be used when the prescription is Dispense as Written by the physician and the drug is reimbursed at the MAC price.

See the section for proper documentation for overriding a MAC drug.

Example: NDC# 00123012301 should be billed as
0012301230A for a MAC override

The inappropriate use of the MAC override

The requirements for the MAC override are based on specific federal regulations which must be followed for Medicaid. Remember to use the MAC override indicator on your drug claims only in those incidents in which the physician's handwritten request to "Dispense as Written" or "Brand Medically Necessary" appears on face of or is attached to the prescription. It is inappropriate to use the MAC override if:

- The drug is not on the MAC list
- You do not have the appropriate handwritten documentation on the prescription

See the section on Maximum Allowable Cost for more complete information.

Procedure for billing compounded prescriptions

All compounded prescriptions must be submitted on a paper pharmacy claim form. Compounded prescriptions can not be billed electronically. To indicate a compounded prescription, place the code 00990000000 in the NDC field on the pharmacy claim form. At the bottom of the claim form, list the drug name, strength, quantity, NDC number, and the cost of each ingredient contained in the compound.

If two different compounded prescriptions are dispensed within one month for the same recipient, bill the second compounded prescription with a code 0099010000 in the NDC field on the pharmacy claim form. Failure to list this code will result in a duplicate denial with the first compounded prescription. If a third compounded prescription is necessary, the code would be 00990200000, and so on increasing the digit in the sixth position as needed.

See the section on Compounded drugs for more complete information.

Billing for nursing home prescriptions and IV therapy

Due to special packaging or storage requirements for nursing home prescriptions and the stability problems associated with IV therapy, a single prescription may have to be dispensed several times during the month in small quantities. Recipients of these prescriptions may quickly reach their prescription limit per month. Because of the special circumstances involved in their dispensing, prescriptions for nursing home recipients and **prescriptions for IV therapy may be billed once per month**. The monthly billed amount should reflect a total of all dispensing for that one prescription for the month less any credit that might have occurred during the monthly period.

Two Months Free Coverage of Betaseron

Berlex Laboratories, the manufacturer of the drug Betaseron, offers two months of free coverage of the drug to patients taking Betaseron for ten months. This offer is extended to all patients, including Medicaid beneficiaries. Medicaid claims for the two free months must not be submitted.

Meridia Coverage

Meridia is reimbursable only for those patients who have a documented diagnosis of morbid obesity. The physician or prescriber is required to write the diagnosis on the face of the prescription in his/her own handwriting. In the absence of such documentation, the prescription will not be covered by the Medicaid program and payment will be the responsibility of the recipient. This policy is subject to audit by appropriate staff in Program Integrity.

Procedure for drugs not on the EDS drug file

If a claim has denied for NDC code not on State file, verify the NDC on the manufacturer's packaging with the NDC submitted. Verify that each digit of the NDC code was entered in the correct block of the NDC field on the pharmacy claim form or the pharmacy software. If the NDC was not correct, please correct the number and resubmit the claim.

If the NDC was correct on the claim form, verify that this number matches the NDC code keyed on the RA if a paper claim was submitted. If the number was keyed incorrectly, please resubmit the claim.

If the NDC code is correct and correct on the claim form, verify that the drug manufacturer is covered under the Drug Rebate Agreement and that the drug is not DESI, OTC, or a device.

New drugs are added weekly to the drug file with retroactive coverage to the marketing release date.

If none of the above facts and verifications resolve drug coverage issues, contact Pharmacy Provider Services at (919) 851-8888 or (800) 688-6696.

Summary of N.C. Medicaid billing requirements:

- Subscriber ID is the recipient's ID number of 9 digits plus 1 alpha character in the tenth position
- UPIN is the prescriber number used to identify the prescriber of the prescription
- Six (6) prescriptions per month limit (see chart of Exceptions to Copay and 6 Rx/month limit)
- Copay is $1.00 (see chart of Exceptions to Copay and 6 Rx/month limit)
- Day Supply Maximum
- Second dispensing of a prescription within the same month will have a $5.60 dispensing fee deducted because no dispensing fee is allowed on additional dispensings of a prescription in the same month
- Compounds must be billed on paper claims with an NDC of 00990-0000-00 with the drug name, manufacturer, NDC, quantity, and cost of each ingredient. Additional compounds billed in the same calendar month need to incrementally increase the 6th digit of the NDC by 1 for each additional compound. e.g. 00990-1000-00 and 00990-2000-00
- Nursing Home providers may wait until the end of the month and combine all dispensings into one prescription
- The Amount Billed should be the lower of Usual & Customary price or the calculated Medicaid price. The calculated Medicaid price is the MAC price or the AWP -10% plus $5.60. Federal MAC prices will be used unless overridden with auditable required documentation.
- MAC overrides are allowed if the prescriber hand writes "Brand Medically Necessary" or "Dispense as Written" on the face of the prescription. MAC overrides are billed with DAW 1 in POS claims and with 0A (numeric zero, alpha A) for paper and ECS claims.
- Other Payor amounts must be included when applicable for Medicaid, as the payor of last resort, to pay the calculated Medicaid price minus the copay and the Other Payor Amount field

- Exclusions from payment:
    * OTCs (over-the-counter non-prescription medications) unless included in covered compounds, except Insulin (Insulin is paid)
    * Devices
    * Diaphragms
    * DESI drugs
    * Compounds equivalent to DESI drugs
    * Fertility or impotence medications
    * Medications for cosmetic purposes
    * Medications for non-FDA approved uses
    * Drugs from manufacturers who have not signed Drug Rebate agreements
    * In-patient hospital prescriptions
    * Drugs administered in prescriber's offices that should be submitted using J codes
    * Routine immunizations
    * Durable Medical Equipment
    * Prescriptions dispensed by non-enrolled providers

Table of Exceptions to Copay and Six Rx/month limit

	Exemption			NCPDP POS		Manual	ECS
Condition	**Co-pay**	**Rx/limit**	**Both**	**Location**	**PA Code**	**Claim**	**Claim**
Six Rx Limit Exemption							
Notation of diagnosis for 6 Rx exemption	N	Y			5	Loc=E	Loc=E
Co-Pay Exemption							
Family Planning Drug	Y	N			6	FP block or Drug File	
Intermediate Care Facility	Y	N		2		7	7
Skilled Nursing	Y	N		7		8	8
Pregnancy	Y	N				P	
Exempt from co-pay only	Y	N			4	Not existing	
Six Rx Limit and Co-pay Exemption							
Healthcheck < 21 years old	Y	Y			4	EPSDT block	
Quantity or Price Adjustments	Y	Y	Y				
CAP	Y	Y	Y			Eligibility file	
<21 years old	Y	Y	Y			Eligibility file	
Exempt from co-pay and six Rx limit	Y	Y	Y		8	B	
Locations with no automatic exemptions							
Hospice	N	N		11			
Rest Home	N	N		5		6	6

Summary of Changes for POS from current claim format for Software:

1. Use of PA/MC code number instead of E in Locator block

   4 = copay exemptions
   5 = Rx limit overrides
   8 = Exempt from copay and Rx limit

2. Use of DAW 1 instead of 0A (numeric zero, alpha A) for a MAC override

3. Use NCPDP location values instead of unique NC values

Type of Facility	NCPDP location	Paper and ECS location
Adult Care Home	5	6
Intermediate Care Facility - MR	2	7
Nursing facility	7	8

4. Submit Usual & Customary in addition to Gross Amount Due (Amount Billed on current paper and ECS formats)

Billing Methods

North Carolina Medicaid Point of Sale (POS) Pharmacy Claims On - line, Real-time

The North Carolina Division of Medical Assistance (DMA) offers providers On-line, Real-time services as an additional way to process pharmacy claims. Paper, modem, and tape claims are still allowed at this time. Each pharmacy will need to work with their software vendor regarding on-line Medicaid capabilities. Claims will be submitted through the "switching" companies.

NC Medicaid hopes pharmacies will utilize the on-line processing option automatically performing eligibility verification, drug validation, pricing, and edits and audits followed by prospective drug utilization review before the pharmacy dispenses a Medicaid prescription. On-line claims will send back immediate assurance of the amount to be paid for the prescription on the next Medicaid check-write. POS should reduce your follow up accounting for Medicaid claims by allowing correction of any errors before the recipient gets the prescription. All reject codes for a claim will be sent back for an on-line claim whereas other submission methods are limited to returning the first reject encountered.

The same policies for MAC Overrides, co-pay exemption, and prescription limit overrides are in effect for POS as for other claims processing media. The current pharmacy of record procedure guarantees the pharmacy with the Medicaid stub exclusive rights to payment for up to six prescriptions per month for the recipient. Prospective DUR screens the patient's profile across multiple pharmacies and prescribers to improve the quality of care and reduce costs by supplying pharmacists with information regarding potential adverse drug incidents and overutilization North Carolina Medicaid Pro-DUR documents pharmaceutical care with National Council for Prescription Drug Programs (NCPDP) DUR Intervention and Outcome codes required to override DUR alerts. Accurate Days Supply are essential for Pro-DUR Minimum and Maximum Dosages.

Most software vendors have been certified capable of meeting requirements to bill NC Medicaid on-line. If you can not do any of the following, please contact your software vendor for assistance. The following functions are the ones you need to make sure your system can perform.

- Override rejects for DUR Conflicts when needed by resubmitting the rejected claim with DUR Conflict, Intervention, and Outcome codes.

- Override the 6 prescription limit when proper documentation is provided by the prescriber sending a 5 as the Prior Authorization (PA/MC code).
- Submit payments from other insurance plans for Medicaid claims in an "Other Payer" field.
- Override MAC prices with DAW 1 when proper documentation is provided by the prescriber
- Send UPIN instead of DEA number as the prescriber identifier

On-line POS Processing Hours

On-line processing will be available from 8 a.m. to 11 p.m. Monday through Saturday and 10 a.m. to 7 p.m. on Sunday. General Medicaid pharmacy questions from 8:30a.m. - 4:30 p.m. weekdays should be directed to NC Medicaid Provider Services at (919) 851-8888 or 1 (800) 688-6696 or from 4:30 p.m. to 5 p.m. weekdays to (919) 233-6846.

All communication/technical POS problems should be directed to your "switch," especially NCPDP reject codes 99 for Host Processing Error.

For Envoy call (800) 333 -6869. For NDC call (800) 388-2316. For QS1 call (800) 845-7558. For MediAmerica call (216) 425-3241 ext. 225.

Requesting On-line POS Processing for Medicaid Pharmacy Claims

Pharmacies may request the on-line claim submission option for North Carolina Medicaid pharmacy claims by completing the attached Pharmacy On-line Request and returning it to the address or fax number on the form. Pharmacies must contact their pharmacy software vendor for:

- The IIN (Industry Identification Number, formerly known as the BIN- Bank Identification Number)
- A processor control number to bill NC Medicaid on-line, real time
- Any other necessary information you need to begin billing on-line using NCPDP 3.2c.

Processing Charge

There are no State or Federal funds for on-line claim processing, so there is a $.095 processing charge per **PAID** claim. There will <u>not</u> be a processing charge for rejects. The Medicaid processing charge with communication charges paid to a "switch" is less than 1% of the cost of the average $27 Medicaid prescription. If on-line processing charges for 100 prescriptions prevent the loss of revenue from the reject of one $27 prescription, the pharmacy breaks even. If on-line processing for 100 prescriptions prevents a loss of revenue from a more expensive prescription, the pharmacy has saved money with charges for on-line verification.

On-line reversals (credits) are allowed for on-line claims for up to 6 months with a processing charge for each successful reversal. After 6 months, reversals must be done manually. Paper, diskette, tape, and batches of modem claims can only be reversed on manual adjustment forms or the quarterly credit report and can not be reversed on-line.

The processing charge for on-line claims is deducted on the same RA that pays the on-line claims. An amount equal to $.095 x the number of paid and reversed claims will be under Point Of Sale Service Chg on the Claims Payment Summary of the RA. The Point Of Sale Service Chg will be deducted from the Net Pay Amount to derive the Adjusted Net Pay Amount. The Adjusted Net Pay Amount will be equal to the amount on the payment check. Questions about on-line charges should be directed to the Technical Point-Of-Sale Help Desk at (919) 233-6846 or (800) 688-6696. On-line claims must be submitted by 12 midnight Thursday in order to be in the next check.

Compound prescriptions still require billing on a PAPER claim with an NDC of 00990-0000-00 and the NDC, drug name, quantity, and price of each ingredient documented on the bottom of the form for proper pricing. You may need to work with your pharmacy software vendor on the procedure to count a compound as one of the six prescription per month even though it is not billed through POS.

POS claims over $1000 will not be paid. Claims over $1000 require manual review for validity. These claims can be billed through traditional non-POS methods of paper, diskette, tape, or batches through modem. There is no prior approval for North Carolina Medicaid.

POS claims must be billed within 7 days of the dispensing date. Older claims may be submitted on paper, tape, diskette, or modem.

Days Supply

Submitting an accurate Days Supply will be very important. Days Supply divided by the quantity will be used to calculate the daily dose for Pro-DUR. Excessively high or low daily doses will result in rejects when High and Low Dose DUR alerts are implemented. In addition to high and low daily dose edits, there will also be edits for too early refill before 75% of the prescription is used and for a 100 day maximum. The 100 day maximum can not be overridden.

Six Prescription Payment for Pharmacy with stub, not for first pharmacy to submit claim

A pharmacy must have the stub from the recipient's card to be assured of payment. On-line does not eliminate the recipient lock-in to one pharmacy per month. On-line is optional and some pharmacies may choose to submit claims on paper, diskette, tape, or in batches through a modem. POS incorporates paid batch claims on the POS prescription profile, but delays between the dates of service, submission, and payment for batch pharmacy claims can prevent timely updates of the POS profile and prescription count. POS will count all prescriptions on file for a recipient for the month and return a reject for the seventh prescription. If the pharmacy with the stub submits the recipient's seventh claim after another pharmacy obtained approval for a POS claim, the approved POS claim will be recouped from the pharmacy without the stub. Please work with your fellow pharmacists when patient care requires a recipient to get prescriptions at more than one pharmacy during one calendar month.

Pharmacies must keep the stub from the recipient's Medicaid card and stamp the card with the pharmacy's Medicaid identification. The pharmacy with the stub has first rights to payment for six prescriptions for that recipient. The pharmacy of record policy will be used to recoup claim payments made to any pharmacy without the Medicaid stub to pay the pharmacy with the stub from the Medicaid card.

Prospective Drug Utilization Review (Pro-DUR)

The purpose of Pro-DUR is to improve the quality of care and promote cost savings by preventing adverse drug events before a prescription is dispensed or used. Pro-DUR is an additional source of information for the pharmacist to use in making decisions affecting pharmaceutical care. Pro-DUR alerts for NC Medicaid prescriptions will create rejects that the pharmacist must respond to before payment is made for a prescription with a standard NCPDP DUR conflict. If the prescription should be dispensed in the pharmacist's professional opinion, the pharmacist must document their professional judgment by responding to DUR alerts. DUR documentation is done by including NCPDP DUR Outcome and Intervention codes with a DUR conflict in order to receive payment for a resubmitted prescription. All information required to respond to the DUR alert is included in the DUR information sent with the alert.

Up to three DUR alerts can be returned for a prescription in the NCPDP standard. If there are more than three DUR alerts, a DUR overflow message will be returned. If the pharmacist wants to dispense a prescription that creates more than three alerts and wants to know the overflow alerts, they may call Pharmacy Provider Services at (919) 851-8888 or 1 (800) 688-6696.

Prescriptions that are rejected with DUR Conflict codes and not overridden will be assumed to be not filled. Return of a Not Filled Outcome code is not required.

Medicaid Pro-DUR is based on a patient's prescriptions from all prescribers and all pharmacies utilizing criteria established by the State and a controllable database updated weekly by First DataBank. The Pro-DUR alerts will be phased in by conflict code after on-line is implemented.

The **procedure for responding to DUR alerts** is as follows:

- Pharmacist receives DUR alert message(s) on computer screen; claim is rejected for DUR
- Pharmacist reviews and resolves identified DUR conflict(s) by contacting the prescriber, talking with the patient, and/or using other resources or professional judgment
- If pharmacist decides not to dispense the prescription, the pharmacist accepts the reject
- Pharmacist does not resubmit claim and does not receive payment
- If pharmacist decides to resolve and dispense the prescription, the pharmacist resubmits the correct claim with a DUR Conflict code, DUR Intervention code, and DUR Outcome code

  Pharmacist receives a paid response if the prescription was filled with DUR documentation

DUR alert messages contain standardized codes and language, but may be displayed in various ways, depending on the pharmacy software in use.

NC Medicaid POS Notes to Share with your Pharmacy Software Vendor

N.C. Medicaid accepts up to 4 claims in an NCPDP3.2c transaction. N.C. Medicaid accepts POS claims from "switches" who convert batches to POS claim transactions. N.C. Medicaid does not plan to add acceptance of 3.2 variable until ready to accept the coming NCPDP 3.2 variable compound format. N.C. Medicaid will only pay NCPDP transaction type 01 claims. N.C. Medicaid accepts 81 information only transactions with a captured response. Reversals are allowed with an NCPDP transaction type 11. Claims with a date of service more than one week prior to the submission date are not accepted through POS and require a manual claim.

N.C. Medicaid monitors Drug Utilization Review (DUR) criteria so that DUR alerts are less than 10% of all POS claims. N.C. Medicaid rejects for DUR alerts found for NCPDP transaction type 01 claims. Assurance of payment for a DUR override requires resubmission of the claim with DUR alert, intervention, and outcome as transaction type 01 claims. Each prescription for DUR alerts is screened across all the prescriptions on file from all providers instead of paying claims prefilled with DUR intervention and outcome codes based only on the submitting provider's profile for the recipient. If N.C. Medicaid does not receive a DUR override, N.C. Medicaid assumes the prescription was not filled instead of requiring submission of an 81 information only with the DUR intervention and outcome codes.

Provider Services at (919) 851-8888 or 1-800-688-6696 can be contacted about specific billing questions.

Directions for Completing the Manual Pharmacy Claim Form

The pharmacy claim form is a multiple claim form presenting lines for billing ten (10) separate prescriptions within the same month of service. It may be used for one recipient or 10 different recipients. Space has been provided at the bottom of the claim form for listing ingredients used in compounded prescriptions. Please be sure claims are legible and all information is within the appropriate blocks before submitting the claims.

Item 1: **PHARMACY NAME - PHARMACY NUMBER:** Enter the pharmacy name and seven-digit provider number clearly in this area. Smeared or illegible numbers may cause denial of claims. If your provider number contains six digits, place a leading zero in front of the number to make seven digits.

Item 2: **SERVICE DATE:** Enter the month and year of service (dispense date). Note that claims for only one calendar month of service can be submitted on the same claim form.

Item 3: **MEDICAID ID NUMBER:** Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the Medicaid Identification Card. If filing two or more consecutive lines for the same recipient, you may write the word "SAME" in the Medicaid ID number field. DO NOT LEAVE THIS SPACE BLANK.

Item 4: **RECIPIENT'S NAME, LAST, FIRST:** Enter the recipient's last name and first name as they appear on the Medicaid Identification Card. If the first name is not indicated, enter the first initial. If filing two or more consecutive lines for the same recipient, you may write the word "SAME" in the Recipient's Name field.

Item 5: **LOCATION (LOC):** Enter the correct number for patient location or exemption from prescription limitation or copay. Code "6" indicates that the recipient is in a Rest Home, "7" indicates that the recipient is in an intermediate care facility (ICF), and "8" indicates that the recipient is in a skilled nursing facility (SNF). A "B" in this field indicates that the patient is exempt from the six prescription limitation and the copay. This would be used for a patient in a SNF, ICF, or a mental hospital. A "P" in this field indicates a pregnancy-related prescription thus exempting co-payment deduction.

NOTE: For all other patients (including rest home patients) who are exempt from the six prescription limitation, indicate the "E" in this field. All patients must abide by the six prescription limitation unless they are in one of the exempt categories listed on page 13 and 14.

Item 6: **SEX:** Indicate the recipient's sex. Enter "M" to signify male or "F" to signify female.

Item 7: **RX NUMBER:** Enter the pharmacy file (prescription) number assigned to the prescription

Item 8: **O/R:** Indicate whether it is the original dispensing of a prescription or a refill with an "O" for the original or a "R" for refill.

Item 9: **PRESCRIBER NAME OR DEA NUMBER:** Enter the prescriber UPIN (Unique Prescriber Identification Number). Pharmacists may obtain a paper directory of UPIN for this region by written request to CIGNA Medicare. The following information is included for your convenience in obtaining this directory:

Telephone: CIGNA Medicare
(615) 244-5600

Address: CIGNA Medicare
P.O. Box 671
Nashville, Tennessee 37202

Directories for other areas can be obtained from the Government Printing Office, Superintendent of Documents, Washington, D.C. 20402.

Interns and residents have uniquely assigned numbers which are called "pseudo" UPINs.

UPIN directories for South Carolina providers are obtained from the following:

Medicare Provider Services
P.O. Box 100190
Columbia, SC 29202-3190

Item 10: **OTHER COVERAGE:** List the amount paid by another insurance company (including Medicare) on that specific prescription.

Item 11: **DAY FILLED:** Enter the day of the month the medication was dispensed. Do not enter month and year in this space. Multiple months may not be billed on the same form.

Item 12: **DRUG NAME, STRENGTH, AND DOSAGE:** Enter legibly the name and strength including dosage form of drug dispensed. If the dispensed drug has a brand name, the brand name must be entered instead of the generic name.

Item 13: **MANUFACTURER (MFG):** The manufacturer's name is required for all generically dispensed drugs and for all brand name drugs that are not nationally distributed products. The manufacturer's name is not required for nationally distributed brand name products. Please be sure to list all local manufacturers along with the pertinent information to aid in identification of a particular drug.

Item 14: **NDC:** Enter the 11-digit National Drug Code. Legibility and proper format are essential.

Item 15: **QUANTITY DISPENSED (QUAN):** Enter the quantity in metric units for the number of ml's or gm's dispensed. For tablets, capsules, or suppositories, enter the count or number dispensed. Do not use Roman numerals. For compounded prescriptions, please list the total quantity dispensed in this field.

Item 16: **ESTIMATED DAYS SUPPLY:** Based upon the quantity, daily supply from the Sig, data on the prescription, and upon your professional judgment, enter the number of days that the dispensed quantity will last the patient when used at the prescribed dosage. This information is required for drug utilization review.

Item 17: **EPSDT:** If the prescribing physician has entered EPSDT on the prescription, mark an "X" in this field to exempt co-payment deduction. The original and any refills are considered to be part of the EPSDT program until the recipient turns 21 years of age. Do not collect copayment on these prescriptions.

Item 18: **FAMILY PLANNING:** If the prescription is for birth control, place an "X" in this field to exempt co-payment deduction. Do not collect co-payment on prescriptions for birth control.

Item 19: **AMOUNT BILLED (DOLLARS/CENTS):** Enter the total amount for each prescription including the cost of the drug plus the professional fee. Do not deduct the lower of the usual and customary charge or co-payment. For all repeat prescriptions within the same calendar month, the Medicaid professional fee and co-payment amounts will be deducted when the claim is processed. If other coverage is indicated, the Amount billed should still reflect the total billed amount.

Item 20: **CLAIM TOTAL:** Enter the sum of the individual "Amount Billed" fields on the claim form. This is for your benefit, we do not process this total.

Item 21: **SUBMISSION DATE:** Enter the month, day, and year of claim submission.

Item 22: **PAGE NUMBER:** Enter the page number for this submission date.

Item 23: **CLAIMANT SIGNATURE:** Each claim form must be signed by the owner or authorized agent who signed the pharmacy program participation agreement. A rubber stamp facsimile of the authorized signature may be used with the understanding that the owner or authorized agent assumes responsibility for information submitted on the invoice and acknowledges this responsibility by authorizing his signature to be stamped on the claim form. The provider's signature on the Medicaid Electronic Claims Agreement is binding as certification that the paperless claims are true, accurate, and complete. To avoid EOB 1350 for claims not signed, please fill out a signature on file form.

Item 24: **COMPOUNDED PRESCRIPTIONS:** List the drug name, strength, quantity, NDC code, and cost for each ingredient contained in the compound. If more than one compounded prescription has been dispensed, file the second compound on a separate claim form if all ingredients can not be described in the space provided in this field.

After completing the claim form correctly with all the required fields, sign the form if you do not have a Signature on File, and mail to:

EDS
P.O. Box 300001
Raleigh, NC 27622-3001

Within 30 days of receipt of a manual claim, the claim will be processed for payment. The Payment Cycles are published in the Pharmacy Newsletters. Payment notification is in the form of a Remittance Advice with a check or Electronic Funds Transfer (EFT).

Electronic Claims Submission (ECS)

Overview

Electronic claims submission (ECS) is the submission of Medicaid claims electronically, over telephone lines, by diskette, or by magnetic tape to Electronic Data Systems (EDS). Claims submitted electronically result in faster payments and a more efficient billing process.

ECS Options

There are four options for electronic claims submission.

Option 1
EDS Electronic Claims Submission Software

A special software package has been developed by EDS to assist providers in electronic claims submission. This software, available at no charge from EDS, requires the use of an MS-DOS (IBM compatible) microcomputer system. Information for each claim is manually entered into the system, and claims are submitted over the telephone (meeting the technical specification for communication with micro ECS) using a modem.

Direct Transmission Vendor/Programmer Software

Direct transmission is the creation of Medicaid claims file by the provider's client accounting software, and the transmission of the claim file to EDS over the telephone (meeting the technical specification for communication with micro ECS) using a modem. The Medicaid claims file must be transmitted as an ASCII file in a format specified by EDS.

Option 2
Mail-In Diskettes

Providers who have computer systems but do not own modems are able to submit claims electronically by mailing a diskette to EDS.

Mail-in submissions are accepted on 5 1/4" or 3 1/2" diskette in low or high density. EDS will return the diskette only if requested and the submitter provides EDS with a return mailing label.

The claim data on the diskettes must be in ASCII format as specified by EDS. File specifications or IBM-compatible software are provided free of charge by EDS upon request.

Option 3
Magnetic Tape

Submitting claims using magnetic tape is done by using the EDS Universal Tape Billing System. The provider's software must produce a nine track magnetic tape with data encoded in EPCDIC with a density of 1600 or 6250 bpi. File specifications, record layouts, and other requirements of the Universal Tape Billing System are available upon request from EDS.

Signature Requirements

The provider must sign and return a written agreement, the N.C. Division of Medical Assistance Electronic Claims Submission Agreement, prior to the transmittal of the first electronic claim requests for payment.

A signature is required for all claims submitted for payment. Because an electronic claim can not be signed, an electronic provider agreement is required. Signing the agreement in no way binds the provider to only submitting electronically. A provider agreement can be received from the ECS Unit at EDS upon request.

Testing Requirements	The system should be tested before claims are submitted for payment. Additional tests will be required if data is not submitted in the EDS required format.
Special Billing Considerations	Certain services must be filed on paper. EDS will supply you with a list of procedure and diagnostic codes that can not be submitted electronically. 1. Claims for compounded prescriptions
Electronic Claims Submission Information	Contact the ECS Coordinator at: EDS 4905 Waters Edge Drive Raleigh, NC 27606 1-800-688-6696 or 919-851-8888

Signature on File for Paper Claims

Many providers submitting paper claims have requested exemption from the provider signature requirement on the claim form. Currently, claims without a provider signature can not be processed and are returned.

Certification for signature on file

Effective August 1, 1995, providers will be able to file claims without an individual signature on each claim if the provider has submitted the **"Provider Certification for Signature on File"** printed on the next page. Remove the page for completion or make a copy of the page and complete. The certification must carry the provider's original signature. Stamped signatures will not be accepted. For group physician/practitioner practices or clinics, each attending provider should sign a certification. For groups such as Home Health, hospitals, etc. that do not require an attending provider number on the claim, the certification should be signed by an individual who has authority to sign contracts on behalf of the provider.

Mail completed certifications at least two weeks in advance of submitting claims without signature to:

EDS
Provider Relations
P.O. Box 300009
Raleigh, NC 27622

Processing of claims without signature:

The claims processing system will be annotated to indicate that the certification for signature is on file. Beginning August 1, 1995, all claims will be checked for the signature on file indicator. If a certification form has not been received by EDS for each provider number and the claim has no signature, it will deny for EOB 1350 "Provider signature not on file. Sign claim and resubmit or complete Certification for Signature on File and return to EDS."

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____

Print or Type Business Name of Provider

_____ _____

Signature of Provider Date

Group provider number to which this certification applies: _____

Attending provider number to which this certification applies: _____

(6/95)

Payment on the Pharmacy Remittance Advice

Effective September 1994, Medicaid began accepting claims for dollar amounts up to $9,999,999.99. This change has prompted the following remittance advice (RA) changes:

- Pharmacy RAs only: The decimal point was removed from the dollar amount fields
    - The gray bars were removed
    - The solid horizontal and vertical lines were removed
    - The report title was changed to North Carolina Medicaid
    - The amount fields were increased to accept the million dollar amount
    - The summary totals will line up under the pre-printed headings

A sample of the new RA appears on the following page.

The RA is a computer generated document showing the status of all claims submitted to EDS along with a detailed breakdown of payment. The RA is produced at the same time that checks are issued.

The RA has six major sections. Each section is composed of information identified by various section headings as outlined below.

Identification Headings

A.	**Provider Name and Address**	Pharmacy Name and Address
B.	**Provider Number**	The 7-digit number assigned to the provider for participation in the North Carolina Medicaid Program. Alpha suffixes, if applicable, will be shown.
C.	**Report Sequence Number**	Assigned sequentially for the provider's convenience to identify the RA. The first RA received each year will be numbered 1, the second 2, etc. Filing RA's in order using this number will help ensure that none are missing.
D.	**Date**	The date the RA was produced. It will match the date on any corresponding checks.
E.	**EDS Report Sequence Number**	EDS' Cumulative Report Sequence Number for all RAs for all providers for the year.
F.	**Page**	The number assigned sequentially, starting at 1, to each page comprising the current RA.
G.	**Pre-Printed Totals Heading**	These headings do not apply to pharmacy details. They are the headings for Totals lines.
H.	**Banner Message**	At times special informational messages will be printed inside a box outline of asterisks on the RA. Attention should be given to these messages as they contain information that will facilitate processing.

Major Sections of the RA

The following is an explanation of the major sections of the remittance advice.

I.	**Identification Headings**	Information about provider and date subsection generalities. Each subsection is listed alphabetically by the recipient's last name. After each subsection, there are summary totals beside identification for that section. These summary totals line-up under the pre-printed headings.
II.	**Paid Claims**	Listing of all the claims paid since the previous checkwrite.
III.	**Adjusted Claims**	Indicates the status of claims when requests for action have been made to correct erroneous payment or any other adjustment.
IV.	**Denied Claims**	Identifies the claims which have been denied for payment because of various improper or incomplete claim entries.
V.	**Claims in Process**	Lists the claims which have been received and entered by EDS but are pending payment because further review of the claim is needed.
VI.	**Claims Payment Summary**	Summarizes all payments and credits made to the provider by the Medicaid program for the specific RA pay period, entitled "Current Processed," as well as for the year, entitled "Year to Date Total." Lists all EOB codes on the RA with explanations.

Column Headings

The following is the key to the Column Headings of the remittance advice.

1.	**Recipient ID**	The recipient's (patient's) 10-digit identification number. Usually their 9-digit social security number with an alpha character in the 10th position.
2.	**Last Name**	The recipient's last name. The RA is alphabetical by the last name within each subsection of claim types.
3.	**First Name**	The recipient's first name.
4.	**MI**	The recipient's middle initial.
5.	**SVC Date**	The service date (date dispensed).
6.	**RX Num**	The 6 digit prescription number or the last 6 digits of a 7 digit prescription number.
7.	**Drug Code**	The National Drug Code (NDC) of the drug dispensed.
8.	**Drug Name**	The drug name for the drug code from the First DataBank file.
9.	**Qty**	The quantity dispensed.

10.	**Claim Number**	The unique 13-digit number assigned to each claim form by EDS for control purposes. Please reference this number when corresponding with EDS about a claim.
11.	**Total Billed**	The amount billed by the provider.
12.	**Total Allowed**	The amount allowed as Total reimbursement by Medicaid including copay for the claim.
13.	**Co-Pay**	The amount the recipient paid or should have paid.
14.	**Total Paid**	The Total Allowed minus (any Dispensing Fee Repeats for dispensings in the same month) minus the co-pays minus any payments by other Third Party.
15.	**EOB Code**	The Explanation Of Benefits is a numeric representation of the message which explains why the claim was adjusted, denied, pended, or paid. A listing for each EOB appearing on the RA is located at the end.
16.	**Summary Line**	The number of claims addressed in the subsection identified at the left of the summary line.
17.	**Total Billed**	The total amount billed by the provider.
18.	**Non-Allowed**	The Total Billed minus the amount allowed by Medicaid.
19.	**Total Allowed**	The amount allowed for the claims.
20.	**Payable Cutback**	The difference between what Medicaid allows and what Medicaid will pay for a particular charge based on the RCC or reimbursement amount.
21.	**Payable Charge**	The amount paid plus co-pay or the total allowed minus the dispensing fee repeats.
22.	**Other Deducted Charges**	Co-Pays.
23.	**Paid Amount**	The total allowed minus any dispensing fee repeats for dispensings in the same month minus the co-pays.

Adjusted Claims

This section of the remittance advice shows the status of claims when requests for action have been made to correct overpayment, underpayment, or payment to the wrong provider. Some of the most common causes of adjustments are clerical errors, incorrect claims information, or incorrect procedure coding. There are no subsections under this heading; however, the word "Adjustment" will appear to identify any adjusted claims. "Credit To" and "Debit To" indicators will identify what portion of the adjustment has taken place.

A "Debit To" indicator means additional monies have been paid to the provider. Beside the "Debit To" portion of an adjustment, a complete detailed breakdown of a positive corrected payment will be reflected as was explained in the Paid Claims Section. It will be identified by an ***Adjustment*** "Debit To," followed by this information:

1. The original claim number being adjusted
2. The date the original claim was paid
3. The positive amount being paid

A "Credit To" indicator shows monies which are to be recouped from the provider for incorrect payments. The "Credit To" portion of an adjustment is reflected in negative amounts. Beside an ***Adjustment*** "Credit To" indicator are the following identifications:

4. The original claim number being adjusted
5. The original paid date
6. The amount to be recouped

The following represents the three types of adjustments that can be made:

A. Repayments — A positive adjustment is necessary when the provider has been underpaid or is owed money. This adjustment will appear as a positive amount in the Paid Amount column. Only the amount which is owed to the provider will be paid.

B. Recoupments — A negative adjustment is necessary when there has been a duplicate payment or the wrong provider has been paid. A recoupment occurs when the full amount of a payment is taken back from the provider.

Adjustment "Credit To" will appear as a notation that an amount of money has been taken from the provider. The recoupment amount is actually applied in the Financial Items section of the RA; therefore, the "Credit To" amount should be coordinated with the "Applied Amount" in the Financial Items section to assure what negative adjustments were actually recouped from the check amount. These amounts can be identified by the recipient's Medicaid identification number, the initial date of service, and the recipient's last name and initial.

C. Recoup-Repay — Recoup-repay adjustments occur when the full amount of an incorrect payment is recouped from the provider and then repaid correctly. This type of adjustment may occur when there is a change in procedure coding or in claim data. A recoup-repay adjustment appears as one entry in the Adjustment section. If an overpayment occurred, an ***Adjustment*** "Credit To" indicator will appear as identification that a negative amount of money has been taken back from the provider. This amount will also appear in the Financial Items section of the RA. It can be identified by the recipient's Medicaid identification number, the initial date of service, and the recipient's last name and initials. If additional money is due the provider, an ***Adjustment*** "Debit To" indicator will show that a positive amount of money has been repaid to the provider.

Only the difference in the money amount will appear on the check. Please be aware that negative amounts will appear in both the Adjustments section and the Financial Items section but will only be deducted on the Financial Items section (see the Applied Amount Column in the Financial Items section of the RA). The Summary totals at the end of the Adjustments section include only positive amounts.

Denied Claims

This section identifies those claims which have been denied for payment because of various improper or incomplete claim entries. Some of the most common reasons for claim denial are eligibility status, billing for noncovered services, and filing time limits. The claims in this section are broken down into subsections to indicate the type of bill that was processed. Recipients' names are sequenced alphabetically under each subsection. A zero will appear in all columns to the right of "Non-Allowed." An explanation code specifying the reason for denial will appear in the far right-hand column.

Summary totals appear after each subsection followed by a grand total of the section. Denied claims are finalized and no additional action will be taken on the claims unless the provider submits an adjustment request.

Claims in Process

This section lists those claims which have been received and entered by EDS but are pending payment because further review of the claims is needed. Please do not rebill a claim shown in this section, as it is already in the system.

How Refunds to the Medicaid Program are Shown on Your Remittance and Status Reports (RA)

When money is returned to the Medicaid program due to erroneous billings, overpayments, etc., the receipt and application of a refund is shown on the RA. Processed refunds are reflected in the Financial Items (next to last page of RA) and the Claims Payment Summary (last page of RA) sections.

Example: A Medicaid refund of $100 for Patient John Doe (Medicaid Identification Number 9XXXXXXXXX) will be displayed with Explanation of Benefit (EOB) 113 in the Financial Items Section of your RA.

EOB 113 - "Refund Amount Applied to 1099 Liability"

How will this affect your payment for that RA? It will **NOT** affect your payment. The Claims Payment Summary page (last page of RA) will appear as follows:

Claims Payment Summary

				(1)	(2)
	Claims Amount	Withheld Amount	Net Payment Amount	Credit Amount	Net 1099 Amount
Current Processed	$1,000.00	0.00	$1,000.00	$100.00	$900.00
Year to Date Total	$2,000.00	0.00	$2,000.00	$100.00	$1,900.00

Only columns **(1) and (2)** are affected by the refund. The 1099 liability has been reduced to ensure only payments you keep are reported to the IRS. Note: Claims Paid, Withheld, and Net Payment amounts are not impacted. For this cycle, a check will be received or electronic transfer into a bank account for a $1,000. Year to date will show a $2,000 total.

Using the RA

1. Retain all RAs to assist in keeping claims and payment records current
2. The last RA the provider receives each year will serve as the annual 1099 form
3. Refer to the RA first if questions arise about a particular claim
4. If the RA cannot resolve questions on claims payment, please correspond with EDS using the following procedures:
    a. Attach a copy of the claim and the specific RA page showing where the questionable payment occurred to the Adjustment/Inquiry form
    b. Indicate on the form the reason for questioning payment and other pertinent information
5. The RA is also a status report. It gives the current status of active claims. Should a submitted claim not appear by the third RA, please inquire about it using the following procedure:
    a. Attach a copy of the claim in question to the Inquiry Form
    b. Assure all the required data and signature is on the copy
    c. Call the Voice Inquiry System

Resubmission of Rejects/Denials

Remittance Advice Rejects and Resubmission

If claims are rejected on the Remittance Advice (RA), read the description of the Explanation of Benefits (EOB) code on the last page of the RA and determine what corrections are needed to receive payment, and resubmit the corrected claim.

Pharmacy Claims Resubmission

If you have claims which have been denied due to error, you may correct the error and simply resubmit the claim so long as it will still reach EDS within the 18 months time limit for resubmittals. Some errors that may be corrected this way are:

- Invalid date of service
- Missing or invalid information such as quantity, billed amount
- NDC not on file (Claims that denied with this message should be checked to assure the correct NDC was listed on the claim form.

If your resubmitted claim will not reach EDS within the one year billing time limit, proper documentation (such as a copy of the RA for the previous claim denial) should be submitted. Attach the claim and RA to a Pharmacy Adjustment form.

If your claim involves a problem concerning eligibility, compare a copy of the Medicaid pharmacy stub to the claim and RA. If all three match, submit a copy of the pharmacy stub, the claim, and the RA showing the denial attached to an Inquiry form to:

Division of Medical Assistance
Claims Analysis Unit
1985 Umstead Drive
Raleigh, North Carolina 27603

The DMA Claims Analysis Unit will update the information on the state eligibility files and resubmit the claim.

How To Avoid a Name/Number Mismatch

Please do not use the recipient middle initial on your claim form when submitting claims. The first and last name are sufficient. Give recipient's Medicaid ID# and name as shown on their Medicaid card or on the eligibility file as in the case of a name change.

Eligibility Follow-up

A recipient's eligibility status may change from one month to the next if his financial and/or household circumstances change. For this reason, providers should request that Medicaid recipients provide proof of eligibility each time a service is rendered. A copy of the Medicaid ID card with valid from and thru dates which cover the date of service is guarantee of payment for covered services. If you have claims denied for eligibility reasons (see list below), the following steps should help you resolve the problem and obtain payment for eligible recipients.

Step 1 - Check for errors on the claim

Compare the recipient's Medicaid ID card to the information entered on the claim form. If the information on the claim does not agree with the recipient's Medicaid ID card, appropriate corrections should be made and the claim submitted as a new claim. Documents verifying eligibility are not required, but any other required documents for medical review or adherence to guidelines must be attached. If the claim is over the time limit, attach the claim and the Remittance Advice (RA) showing the denial to a completed inquiry form and submit to the EDS Provider Relations Unit requesting that the time limit be overridden.

Step 2 - Check for data entry errors

If the information entered on the claim form agrees with the recipient's Medicaid ID card, compare the claim form with the RA. If the recipient's name, ID number, or date of service has been keyed incorrectly according to the RA, resubmit the claim. If the claim is over the time limit, follow the guidelines mentioned in Step 1.

Step 3 -Mail Information Required for Eligibility Validation

If information on the claim, the recipient's Medicaid ID card, and the RA match, complete an inquiry form and attach a copy of the Medicaid ID card, the claim, and the denial RA. The Claims Analysis Unit will update the information on the State eligibility file and resubmit the claim. **Do not send the information to EDS as this delays payment of the claim**. Forward the information to:

Claims Analysis Unit
Division of Medical Assistance
1985 Umstead Drive
Raleigh, NC 27603

Eligibility Related EOB Codes/Messages

011 Recipient not eligible on service date

120 Recipient MID number missing

143 Medicaid ID number not on State eligibility file

191 Medicaid ID number does not match patient name

Explanation

The client may be ineligible, the patient identification information on the billing form may be incorrect, or the information may have been entered in error during claims processing.

Pharmacy of Record Adjustments

If you receive a denial for exceeding the prescription limitation and your records indicate that you have not dispensed the prescriptions limit for that recipient within the calendar month, please complete a pharmacy adjustment request. The adjustment request must be accompanied by a copy of the pharmacy stub indicating that you were the pharmacy of record for the month of service in question. Also attach a copy of the denial on your remittance advice (RA) if possible and a copy of your claim so that EDS can refile your claim for processing when the adjustment process is complete.

If you are not the pharmacy of record and one of your claims is recouped due to a pharmacy of record adjustment, you will no longer be informed via letter by EDS. Instead you will receive EOB 907, "Full recoup per pharmacy of record review" on your RA under the adjustments section.

Time Limit Overrides

All claims must be submitted to EDS within 365 days of the date of service. If your claim was paid incorrectly or if you were denied payment then you have 18 months from the date of the remittance advice (RA) denial to resubmit your claim for processing. To assure prompt and accurate handling of claims by EDS, please read and follow these instructions:

1. File an adjustment request when a partial payment was received on a claim. These claims should never be resubmitted as new claims. Complete all the requested information on the adjustment form and clearly state the reason for the adjustment. Attach a copy of the RA showing the payment received.

2. Claims initially submitted within the one year billing limit which were denied can be resubmitted for payment. Review the claims to ensure that previous mistakes, omissions, NDCs, etc., have been corrected. Attach the claim to a pharmacy adjustment request form and note on the adjustment to "Override Time Limit, Documentation Attached." Attach a copy of the RA page for the claim in question to support that the claim was originally submitted within 365 days of the date of service. Mail time limit requests to:

   EDS
   PO Box 300009
   Raleigh, NC 27622

Requirements of Pharmacy Providers Regarding Auditing and Review

Pharmacy Audits and Record Retention

Pharmacy records will be audited periodically. The purpose of these on-site audits is to ensure that the contractual agreement with the State of North Carolina is being upheld. This contractual agreement between the pharmacy provider and the State of North Carolina requires that the provider agrees:

> To maintain as a permanent record, an individual prescription for each drug submitted for reimbursement under this agreement, and to file said prescriptions numerically and in chronological order, either in normally "occurring" order with other prescriptions filled by the provider, or in a separate file, to record each refill on the back of the prescription, and to preserve these records for a period of at least (5) years."

Pharmacy providers utilizing automated data processing systems as record keeping systems must be able to produce sight-readable documents of all original and refilled prescription information. The term sight-readable means that a representative of the State of North Carolina shall be able to examine the record and read the information from a CRT, microfiche, microfilm, or hard-copy printout. These records must be retained for a period of at least five (5) years.

Pharmacy providers submitting paper claim forms must retain a copy of the claim form for a period of at least five (5) years.

Record Retention

The following is a copy of that part of the North Carolina Administrative Code which addresses the retention of records by Medicaid providers for Medicaid recipients.

.1017 RECORD RETENTION

All Title XIX providers shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement. These records shall be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements.

History Note: Statutory Authority G.S. 108A-25(b); 108A-54; 108A-63;1 108A-64; 42 CFR part 455; Eff. April 1, 1988.

Technique For Projecting Medicaid Overpayments

(a) The Medicaid agency will seek restitution of overpayments made to providers by the Medicaid program.

(b) The agency will use a Disproportionate Stratified Random Sampling Technique in establishing the provider overpayments only for repeat offenders.

(c) This technique is an extrapolation of statistical sampling of claims used to determine the overpayment for recoupment.

(d) The provider may challenge the validity of the findings in the SAMPLE itself in accordance with the provisions found in Rule .0402 and .0403.

(History Note: Authority G.S. 108A-25(b); 108A-54; 108A-63; 42 C.F.R. Part 455; eff, October 1, 1987)

In order to keep recoupment amounts to a minimum, we encourage providers to use the Medicaid policy and billing information in the provider manuals and the monthly Medicaid Bulletins. Should you or your staff have questions about the policies or billings, it is vital to contact your EDS representative at (919) 851-8888 or (800) 688-6696.

Program Integrity Reviews

Program Integrity Pharmacy Review auditors conduct routine post-payment audits of pharmacies. If an audit results in a recoupment, the provider has three options:

1. Send a check to repay the overpayment. The address for submitting the check will be in the post-payment letter.

2. Do nothing. The overpayment will be deducted from the future claim payments by EDS.

3. Request a reconsideration review. This review is now done by a Division of Medical Assistance Hearing officer. As instructed in the post-payment recoupment letter, documentation is submitted to the Hearing Office within fifteen working days of receipt of the letter.

If you have questions, please contact Kim Meymandi, Chief Hearing Officer, at 919-857-4016 or Mary Williford, Pharmacy Review Section Chief, at 919-733-3590.

Medicaid Overpayments

The Program Integrity Section of the Division of Medical Assistance conducts regular post payment reviews in an ongoing attempt to assure that Medicaid payments are made only for the services that are covered under Medicaid policy and billing data and supporting documentation are consistent with the service rendered and Medicaid policy. When overpayments are identified, the provider is given written information about the errors and is required to refund the overpayment amount. It is vital that providers use these overpayment notices to educate billing staff concerning the importance of following Medicaid policies. If additional assistance is needed, the provider may request a visit by a provider representative from EDS.

Extrapolation

Effective September 1, 1990, the Medicaid Program implemented a process of extrapolation when determining the amount of overpayment the program has made to providers. This will be used for those providers who are being reviewed by Program Integrity as repeat offenders. To accomplish this, a statistically valid sample of claims and recipients from the provider's claims will be reviewed. The errors identified in the sample will be used to project the errors that occurred in the universe of that provider's claims from which the sample was drawn. The total amount of overpayment to be recouped will be determined by the errors projected in that provider's universe of claims.

Overview of The Drug Use Review Program

In accordance with Section 1927 (g) of the Omnibus Budget Reconciliation Act (OBRA) of 1990, North Carolina established January 1, 1993, a drug use review (DUR) program for outpatient drugs to assure that the prescriptions dispensed to Medicaid recipients are:

- Appropriate
- Medically necessary
- Not likely to result in adverse medical results

The program enhances the quality and appropriateness of patient care by educating physicians and pharmacists on common drug therapy problems to improve prescribing and dispensing practices for Medicaid recipients. The DUR program consists of the following components:

1. DUR Board

   The Board is composed of licensed, actively practicing physicians and pharmacists who have expertise in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs, drug use review, evaluation, and intervention. The activities of the DUR Board include the establishment of standards, retrospective DUR, and ongoing educational interventions.

2. Prospective DUR

   A. A prospective review of drug therapy is conducted at the time a new prescription is filled or delivered. This review involves comprehensive screening of the prescription. Potential drug therapy problems based upon predetermined standards include, but is not limited to:

   - Therapeutic duplication
   - Drug disease contraindications
   - Drug interactions
   - Incorrect drug dosage or duration of therapy
   - Drug allergy interactions
   - Clinical abuse/misuse

   Pharmacies participating in Medicaid must conduct the prospective DUR screening. To comply with these standards, pharmacies must use either a prospective DUR software database or written standards consistent with the DUR Board policy. Additional Pro-DUR screening is provided for claims submitted using Point-Of-Sale (POS).

   B. Counseling - Pharmacists must offer to discuss with each Medicaid recipient presenting a prescription those matters which they, in their professional judgment, deem to be significant. This counseling may include but is not limited to:

   - Name and description of the medication
   - Dosage form, dosage, route of administration, and duration of therapy
   - Special directions, precautions for preparation, administration, and use by the patient
   - Common severe side effects, adverse effects or interactions, drug allergies, and therapeutic contraindications

D

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- Techniques for self monitoring
- Proper storage
- Refill information
- Actions in case of a missed dose

Although the patient may refuse counseling, the offer must be made.

C. The pharmacies are required to make a reasonable effort to obtain, record, and maintain information on Medicaid recipients receiving prescriptions to include at least the following information:

- Patient's name, age, gender, address, and phone number
- Individual patient history including a list of medications and devices
- Pharmacist's comments

The Division of Medical Assistance will monitor compliance with the requirements for prospective DUR screening, counseling, and maintenance of patient information as required by federal law and regulations.

3. Retrospective DUR

OBRA '90 requires that DMA use Medicaid paid claims data to conduct ongoing periodic assessments to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients or patterns associated with specific drugs or groups of drugs. These analyses are based on explicit predetermined standards to include the screens as described in the prospective review process.

OBRA '90 also requires that the DUR program introduce remedial strategies, when necessary, to improve the quality of care for Medicaid recipients and to conserve program funds. These strategies include educational intervention, general or specific information dissemination, or intensified review or monitoring of practitioners. The DUR Board determines the interventions that will be used and evaluates the results after an appropriate amount of time to determine the effectiveness on improved drug therapy.

Retrospective DUR is well suited for identifying aggregate provider-centered prescribing problems. The integration of prospective DUR on-line and retrospective DUR has the potential to promote improved prescribing practices and patient outcomes. RetroDUR can detect new relationships and problems among medications and diseases and can be used ongoing to update the ProDur systems.

RetroDUR is theoretically designed to:

- Detect the full range of prescribing problems
- Recommend corrective actions for controlling costs and improving patient outcomes
- Improve rational prescribing
- Identify preventable drug therapy problems
- Remind physicians of basic principles and provide up-to-date information needed for optimal prescribing
- Promote proactive pharmacy intervention processes
- Evaluate the effectiveness of interfacing Medicaid programs

DUR is education of prescribers and pharmacists to improve the quality of care for Medicaid recipients while reducing expenditures. Primary tangible cost reductions will be effected by:

- Prescribing and dispensing of equally effective, less expensive drugs
- Decreasing the incidences of unnecessary therapeutic duplications
- Averting prescribing problems that may precipitate unnecessary physician visits, ER visits, and hospitalizations

PROFILING SYSTEMS USED BY THE RETROSPECTIVE DRUG USE REVIEW PROGRAM

The Drug Use Review (DUR) Program uses two retrospective profiling methods to characterize drug use patterns and to help providers assure the quality of care in prescribing medications. These methods are Provider Profiling and Recipient Profiling.

• PROVIDER PROFILING

The Provider Profiling System uses the Universal Prescriber Identification Number (UPIN) to identify prescribing practices which deviate from accepted norms. These norms are taken from the published literature or developed by the DUR Board. Pharmacy Medicaid provider numbers are used to identify similar dispensing practices.

The Provider Profiling System accommodates criteria within the following major multi-factor problem types:

- Overtreatment
- Undertreatment
- Treatment failure
- Drug-to-diagnosis interactions
- Drug-to-drug interactions
- Iatrogenic effects
- Adverse effects
- Therapeutic duplication
- Drug use without diagnosis
- Drug use without laboratory/diagnostic procedures
- Empiric prescribing
- Specialty-prescriber use issues

Providers who accept in the Provider Profiling System receive an educational letter and a profile showing every drug claim paid using the prescriber's UPIN for each Medicaid patient who received the specific drug therapy. The packet also includes prescribing information related to the specific drug therapy and response sheets for providers to indicate the appropriateness and usefulness of the intervention to the individual's practice.

• RECIPIENT PROFILING

Recipient Profiling is designed to use specific criteria to characterize drug utilization patterns among recipients. The criteria can identify the following multi-factor problem types:

- Overutilization
- Underutilization
- Treatment failure
- Drug-to-diagnosis interactions
- Drug-to-drug interactions
- Iatrogenic effects
- Adverse reactions

Profiles, which show all of the medical and drug claims paid for a particular recipient, are produced. DUR staff and review committees review these profiles and decide if the providers involved in the recipient's care should receive educational letters explaining the concern for the appropriateness and necessity for the drug therapy and the possibility of said therapy resulting in clinically significant adverse effects. The packets sent to prescribers and pharmacists include the educational letter, recipient profile, pertinent information relating to the drug therapy issue, and response sheets indicating the usefulness of this intervention to the individual's practice.

Medicaid Statutory DUR Requirements and Impact on Pharmacies

The Omnibus Reconciliation Act of 1990 (OBRA 90) required that the drug use review (DUR) program be implemented by January 1, 1993. The following guidelines are provided to assist retail pharmacies in complying with the DUR program.

I. Patient Profiles

Statutory Requirement

Section 1927 (g)(2)(A)(ii)(II) of the Act requires the pharmacist to make a reasonable effort to obtain, record, and maintain for Medicaid recipients the following information:

- Name, address, telephone number, age (or birth date), and gender
- Individual history where significant, including disease state(s), known allergies, drug reactions, a comprehensive list of medications, and relevant devices
- Pharmacist comments relevant to the patient's drug therapy

Impact on Pharmacies

1. The pharmacist, as defined in State Pharmacy Practice Acts, is responsible for collecting, recording, and maintaining patient profile information.

2. The pharmacist may rely upon ancillary personnel to collect, record, and obtain patient profile information, but the pharmacist must review and interpret patient profile information and clarify confusing or conflicting information.

3. Once patient information is obtained, this information shall be reviewed and updated by the pharmacist or registrant before each prescription is filled or delivered, typically at the point-of-sale or point of distribution to screen for potential drug therapy problems listed under the "screening" section below.

4. A "reasonable effort" to obtain profile information will be a good faith effort to obtain from the patient or representative the foregoing patient's information.

5. It is expected that the pharmacist will be guided by professional judgment as to whether and when individual history information should be sought from the physician or other health care providers.

II. Screening

Statutory Requirement

1. Section 1927 (g)(2)(A) of the Social Security Act (the Act) requires prospective DUR at the point of sale or distribution before each prescription is filled or delivered to Medicaid recipients. This review shall include screening for potential drug therapy problems due to:

    - Therapeutic duplication
    - Drug disease contraindications
    - Drug interactions
    - Incorrect dosage or duration of drug treatment
    - Drug allergy interactions
    - Clinical abuse/misuse

2. Prospective DUR screening must use predetermined standards which are based upon the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia Drug Information
- American Medical Association Drug Evaluations
- The peer reviewed medical literature

Impact on Pharmacies

1. Prospective DUR screening is the responsibility of each Medicaid participating pharmacy.

2. Medicaid will supplement DUR on POS claims with alerts for:

    - Therapeutic duplication
    - Drug disease contraindications
    - Drug interactions
    - Incorrect dosage

3. Pharmacies may use commercially available DUR data base packages to assist with prospective DUR. Pharmacies are not required to have their data bases/software certified by the State DUR Board.

4. Such data base packages must be able to screen for the therapeutic problems specified in the statute using explicit standards.

5. It is not expected that these data bases will contain patient-specific diagnosis or allergy information. When, in the pharmacist's professional judgment, obtaining such information is essential to the health and well-being of the patient, the pharmacist should consult the patient or the patient's health care provider.

6. Pharmacies without computers, or those who choose not to use prospective DUR data base packages, must undertake prospective DUR screening manually.

7. To perform prospective DUR screening manually, the pharmacist must screen using predetermined standards which are based upon the listed compendia.

III. Patient Counseling

Statutory Requirement

Section 1927 (g)(2)(A)(ii)(I) of the Act requires that pharmacists offer to discuss with each Medicaid recipient or a caregiver, in person whenever practicable, or by toll free telephone for long distance calls, matters which in his/her professional judgment the pharmacist deems significant. Such counseling is subject to standards for counseling under the State Pharmacy Practice Act. Such counseling is to be provided unless refused by the Medicaid recipient or caregiver.

The statute lists the following subjects for inclusion in counseling:

- The name and description of the medication
- The route, dosage form, dosage, route of administration, and duration of drug therapy
- Special directions and precautions for preparation, administration, and use by the patient
- Common severe side or adverse effects of interactions and therapeutic contraindications that may be encountered, including how they may be avoided and the actions required if they occur
- Techniques for self-monitoring drug therapy
- Proper storage
- Prescription refill information
- Action to be taken in the event of a missed dose

Impact on Pharmacies

1. The pharmacist, as defined in State Pharmacy Practice Acts, is responsible for the offer to counsel and for conducting of counseling when it occurs.

2. The pharmacist may have ancillary personnel make the offer of counseling, but the pharmacist must personally conduct counseling if the offer is accepted.

3. Pharmacies whose primary patient population is accessible through local measured or toll free exchange are not required to offer toll free service.

4. Pharmacists will be required to, at least, document refusal to accept an offer of counseling. States may impose additional documentation requirements with regard to counseling. Records resulting from compliance with the DUR requirements shall be maintained for five (5) years in accordance with Medicaid guidelines.

5. States may choose to apply counseling requirements to all recipients of prescriptions, not just Medicaid recipients.

6. Counseling requirements apply to both new and refill prescriptions. However, professional judgment shall be exercised in determining whether or not to offer counseling for prescription refills.

7. Alternative forms of patient information (such as written material) may be used to supplement patient counseling, but cannot be used as a substitute for counseling.

8. The content of counseling is governed solely by the professional judgment of the pharmacist.

The Medicaid DUR requirements have been incorporated into the State of North Carolina Pharmacy Practice Act and are therefore consistent with the requirements of the Board of Pharmacy except in two areas:

1. The Medicaid requirements address manual prospective DUR screening in the absence of a computer DUR database/software package

2. All records or documentation pertaining to DUR for Medicaid patients must be retained for five (5) years rather than the State Board of Pharmacy requirements of three (3) years

Requirement for Accurate Data on Pharmacy Claims

The DUR program depends on the submission of accurate data on pharmacy claims to minimize false positives and unnecessary referrals to prescribers and pharmacies.

The following fields on the pharmacy claims are **very important**:

1. Days Supply

   The DUR Program uses this information to compute the dose per day, which is often an indication of the therapeutic use. For example, a once daily dosing of cimetidine 400 mg. would indicate that the medication is maintenance therapy as opposed to acute therapy. The information provided in this field is also used as an indicator for determining if the recipient overutilizes or underutilizes medications, as well as identifying potentially inadequate dosing and excessive dosing.

2. Prescriber Identification Number

   The correct Medicaid prescriber identification number is critical in identifying the prescribers and pharmacists involved in the recipient's drug therapy. A recipient with multiple prescribers often risks medication complications of a different magnitude than a recipient using one primary provider. One of the functions of DUR is to determine if the recipient's use of multiple prescribers results in overutilization of services. The North Carolina Medicaid Program uses the UPIN to identify the prescribers on the pharmacy claim. It is imperative that the UPIN be entered accurately on the claim. If the prescriber does not have a UPIN, then the pharmacist should notify the DUR staff at 919-733-3590.

3. Quantity Dispensed

   The accuracy of the data entered in this field is critical to the DUR Program and the Drug Rebate Program. The quantity and days supply are used to calculate the dose per day.

POS/ON-LINE PROSPECTIVE

DRUG USE REVIEW

MANUAL

INTRODUCTION

According to federal law enacted in 1990, pharmacists must maintain patient medication records; must screen prescriptions for potential therapeutic problems before medications are delivered to patients; and must counsel patients on all new or changed prescriptions and on refills when the pharmacist deems it warranted or the patient requests it.

OBRA '90 AND OUTPATIENT DRUG USE REVIEW

Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA'90) mandate that each State Medicaid agency establish a comprehensive drug use review (DUR) program. The law also require that states establish a DUR Board to assist in reviewing criteria, establishing standards and assessing their effect upon the quality of care delivered to Medicaid beneficiaries. The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical events.

DUR is an administrative process of utilization review and quality assessment. It includes predetermined criteria to describe appropriate medical care and standards to define the allowable deviation from the criteria.

The predetermined criteria used in the DUR program must meet the following requirements:

- Source materials must be consistent with the peer-reviewed medical literature, American Hospital Formulary Service Drug Information, United States Pharmacopoeia-Drug Information, and American Medical Association Drug Evaluations
- Differences among source materials are resolved by consensus of physicians and pharmacists
- Criteria are non-proprietary and readily available to providers of services
- Criteria are clinically based and scientifically valid
- Criteria are tested against claims data prior to adoption
- Predetermined standards for prospective and retrospective DUR are compatible
- Criteria are subject to ongoing evaluation and modification either as a result of actions by their developer or by the DUR Board

ON-LINE PROSPECTIVE DRUG USE REVIEW

OBJECTIVES

The objective of on-line prospective DUR is to assist pharmacists in screening select drugs for potential drug therapy problems before the prescription is delivered to the patient.

POINT OF SALE (POS) SYSTEM OPERATIONS

Prior to DUR processing, pharmacy claims will be processed by the on-line adjudication system to verify recipient eligibility, ensure validity (valid dates, NDC numbers, pharmacy and prescriber provider numbers), determine appropriate payment, and comparison with previously paid claims to enforce program service limitations and nonpayment for duplicate claims. The online system utilizes the same processing methodology as paper or electronic batch claim submissions.

PROSPECTIVE DRUG USE REVIEW (DUR) SYSTEM

DUR processing begins after the claim is certified payable. Incoming drug claims are compared to the patient's pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for all problems discovered by this review.

On-line prospective DUR provides for review of drug therapy before each prescription is filled or delivered to the patient and includes screening for potential drug therapy problems due to:

- Drug-drug interactions
- Therapeutic duplication
- Incorrect drug dosage (low dose or high dose)
- Overutilization (clinical abuse/misuse)
- Underutilization (clinical abuse/misuse)

Prospective DUR applies to systemic drug dosage forms as well as non-systemic forms. Systemic routes of administration include parenteral, buccal, inhalation, translingual, sublingual, transdermal, oral, rectal, vaginal, mucous membrane and nasal dosage forms. Non-systemic refers to dental, irrigation, urethral, ophthalmic, otic and topical dosage forms.

NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP) STANDARDS

Pharmacy claim telecommunication standards dictate the order and content of the fields relayed to the pharmacist when a DUR alert is generated. A description of these fields follows.

Conflict Code

Alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria

Clinical Significance/Severity Index Code

Indicates database-assigned significance of the conflict
0 = Not applicable, 1 = Major, 2 = Moderate, 3 = Minor,

Other Pharmacy Indicator

Informs the pharmacist of the originating location of the claim with which the incoming drug claim conflicts
0 = Not applicable, 1 = Your Pharmacy, 3 = Other Pharmacy

Previous Date of Fill

The last recorded date of the active medication in the patient's history file with which the incoming drug claim conflicts

Quantity of Previous Fill

Quantity of previously filled prescription with which the incoming drug claim conflicts

Database Indicator

Identifies source of DUR conflict information
0 = Not applicable, 1 = First DataBank

Other Prescriber Indicator

Identifies the prescriber of the previously filled prescription with which the incoming drug claim conflicts
0 = Not applicable, 1 = Same Prescriber, 2 = Other Prescriber

Free Text Message

30-character field that transmits decoded information regarding the DUR conflict

NC Medicaid will use this for the Drug Name and Strength of the conflicting drug, the health condition contraindicated in Drug-Disease conflicts, or the minimum and maximum dose for utilization conflicts.

NCPDP DUR CODES

Conflict Codes from Medicaid	**Additional Message Text**
DD - Drug-Drug Interaction	"Drug Name with Strength" of interacting drug
TD - Therapeutic Duplication	"Drug Name with Strength duplicates this Rx"
ER - Overuse Precaution	"Refill is ____ days early"
LR - Underuse Precaution	"Refill is ____ days late"
DC - Drug-Disease Precaution	"Condition contraindicates use of prescribed drug"
LD - Low Dose Alert	"Minimum dose, Maximum dose, dose unit"
HD - High Dose Alert	"Minimum dose, Maximum dose, dose unit"

Intervention Codes from Pharmacist

- M0 - Prescriber Consulted
- P0 - Patient Consulted
- R0 - Pharmacist Consulted Other Source
- 00 - No Intervention
- Blank Not specified

Outcome Codes from Pharmacist

1A - filled, False Positive
1B - Filled Prescription as is
1C - Filled with different dose
1D - Filled with different directions
1E - Filled with different drug
1F - Filled with different quantity
1G - Filled with prescriber approval
2A - Prescription not filled
2B - Prescription not filled - directions clarified

DUR ALERT MESSAGE EXAMPLES

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. The following examples are provided to acquaint the reader with the standard content of DUR messages. These may differ from the message actually displayed on the pharmacist's computer screen.

I. On July 6, 1996, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving warfarin prescribed by the same physician and filled at another pharmacy. The messages related to the alert are:

CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19960630 (June 30, 1996)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin

II. On July 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:

CONFLICT CODE:	ER - OVERUTILIZATON
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19960628 (June 28, 1996)
QUANTITY OF PREVIOUS FILL:	90
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber

III. The pharmacist attempts to dispense a refill of levothyroxine on June 15, a date equal to greater than 125 percent of previous prescription's days supply:

CONFLICT CODE:	LR - UNDERUTILIZATION
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19960501 (May 1, 1996)
QUANTITY OF PREVIOUS FILL:	30
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber

VII. The pharmacist attempts to dispense acetaminophen w/codeine, three tablets every 4 hours (dose exceeds usual adult daily maximum):

CONFLICT CODE:	HD - HIGH DOSE
DATABASE INDICATOR:	1 = First DataBank

VIII. The pharmacist attempts to dispense propranolol 20mg, 1 daily (dose is less than usual adult daily minimum):

CONFLICT CODE:	LD - LOW DOSE
DATABASE INDICATOR:	1 = First DataBank

DUR ALERT PRIORITY

Up to three DUR alerts for a prescription can be relayed to the pharmacist on line. To access any additional alerts pertaining to the prescription, the pharmacist should call the E.D.S. POS Help Desk at **1-800-688-6696.**

Multiple alerts on a prescription are prioritized according to the following hierarchy *(subject to DUR Board approval)*:

drug-drug interactions
therapeutic duplication
incorrect dose
drug-disease contraindications
overutilization
underutilization

DUR ALERT DEFINITIONS

Drug-Drug Interactions

Drug-drug interactions create the potential for an adverse medical event when patients receive simultaneous prescriptions with conflicting pharmacology. The Drug-Drug Interaction screening system warns pharmacists when a patient receives drugs which result in a different pharmacologic response from that which is expected when the drugs are given separately. This screen accounts for serum half-life when editing for active medications in the patient's medication history. The pharmacist is notified when severity level 1 interactions occur, i.e., those that are the most significant, usually requiring action to reduce risk of serious injury.

Therapeutic Duplication

Therapeutic duplication is the prescribing of two or more drugs from the same therapeutic class such that the combined daily dose increases the risk of toxicity or incurs additional program costs without additional therapeutic benefit. The Therapeutic Duplication screening system warns pharmacists when a claim is submitted for a systemically absorbed drug that shares the same therapeutic class or a non-systemic drug with identical route of administration and same therapeutic class as another drug currently in the patient's active medication history.

Incorrect Dosage

An incorrect dose is one which lies outside the adult daily dosage range necessary to achieve therapeutic benefit. The Incorrect Dosage screening system alerts pharmacists when doses fall outside the normal adult range for common indications for the drug. Patient-specific information is not required since dose ranges are predicated on a 70 kg adult male with normal hepatic and renal function. Pediatric and geriatric doses are not included in the incorrect dosage alert. Claims for patients 18 years and under are not subject to the Low Dose alert.

Drug-Disease Contraindication

Drug-disease contraindications create the potential for an adverse medical event when patients receive prescriptions which are contraindicated in the patient’s disease state. A Drug-disease contraindication occurs when certain drugs are prescribed for recipients with specific medical conditions that may be aggravated by the new drug prescribed. Diseases are inferred from the indication of drugs on the recipient’s profile.

Overutilization

Overutilization is use of a drug in quantities or for durations which put the patient at risk of an undesirable effect due to a course of drug therapy. The Overutilization screening system warns pharmacists when patients attempt to obtain early refills.

Underutilization

Underutilization is use of a drug in insufficient quantity to achieve a desired therapeutic effect. The Underutilization screening system warns pharmacists when subtherapeutic patterns of prescription use are detected by a patient's failure to renew prescriptions for maintenance drugs on a timely basis.

ON-LINE DUR CRITERIA

Drug-Drug Interactions (DD)

Processing: The drug interaction edit screens each new claim against all active medications in the patient's pharmacy claims history file. To account for residual drug in the body, a factor of 15 percent is added to each active claims' days supply. Severity level 1, major significance, interaction alerts are sent to the pharmacist.

Alert: DD - Drug-Drug Interaction

Message: (Label name)

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing medication profile to identify interacting drugs.

Therapeutic Duplication (TD)

Processing: The Therapeutic Duplication edit screens incoming prescriptions against all active drugs in a patient's claims history. Duplication exists when a patient receives two systemically absorbed drugs or two non-systemic drugs by the same route of administration that share the same therapeutic class.

Alert: TD - Therapeutic Duplication

Message: (Label name)

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing drug profile to identify products in the same therapeutic categories.

Incorrect Dosage (LD/HD)

Processing: The Incorrect Drug Dosage screen creates warnings when the prescribed dose is outside the usual adult range for common indications for that drug. Pediatric doses are checked using ten levels of age - weight minimum and maximum doses for recipients less than 18 years old.

Alerts: HD - High Dose
LD - Low Dose

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must screen prescriptions against the usual adult daily dose for a 70 kg adult male with normal hepatic and renal function.

Drug-Disease Contraindication (DC)

Processing: The Drug-Disease Contraindication edit screens each new claim against all medications in the patient's pharmacy claims history file. A Drug-Disease Contraindication occurs when certain drugs are prescribed for recipients with specific medical conditions that may be aggravated by the new drug prescribed. Diseases are inferred from the indication of drugs on the recipient's profile.

Alert: DC - Drug-Disease Contraindication

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must maintain ingredient-specific patient profiles. Prior to dispensing any medication, the prescription must be checked against the existing medication profile to identify any drug-disease contraindications.

Overutilization (ER)

Processing: The Overutilization screen warns the pharmacist of early refills and/or potential abuse situations. This screen identifies prescriptions submitted for another supply of the same drug when the patient's medication history shows greater than 25 percent of the previously dispensed days supply remains.

Alert: ER - Overuse Precaution

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must maintain accurate prescription dates of service. Prior to dispensing any medication, prescriptions must be checked against the existing drug profile to identify products with identical route of administration and active ingredient(s). If previous prescriptions for identical products have at least 25 percent of the days supply remaining, early refill is present.

Underutilization (LR)

Processing: The Underutilization screen creates warnings when subtherapeutic patterns of prescription use are detected. Alerts are generated when patients fail to renew prescriptions for maintenance drugs on a timely basis. Pharmacists are notified when the renewal request interval is greater than 125 percent of the previous days supply.

Alert: LR - Underuse Precaution

Manual DUR Protocol:

Pharmacists using explicit written criteria (manual DUR) must maintain accurate prescription dates of service. Prior to dispensing any medication, prescriptions must be checked against the existing drug profile to identify products with identical route of administration and active ingredient(s). If previous prescriptions for identical products exceed 125 percent of the days supply, late refill is present.

The procedure for responding to DUR alerts is as follows:

- Pharmacist receives DUR alert message(s) on computer screen; claim is rejected for DUR
- Pharmacist reviews and resolves identified DUR conflict(s) by contacting the prescriber, talking with the patient, and/or using other resources or professional judgment
- If pharmacist decides not to dispense the prescription, the pharmacist accepts the reject.

  Pharmacist does not resubmit claim and does not receive payment.
- If pharmacist decides to resolve and dispense the prescription, the pharmacist resubmits the correct claim with a DUR Conflict code, DUR Intervention code, and DUR Outcome code

  Pharmacist receives a paid response if the prescription was filled with DUR documentation.

DUR alert messages contain standardized codes and language, but may be displayed in various ways, depending on the pharmacy software in use. The **content of the DUR Alert message** includes:

Conflict Code

This two-character alphabetic code identifies the conflict between the submitted drug claim and information in the patient's history file or predetermined screening criteria.

Clinical Significance/Severity Index Code

This numeric value indicates the database-assigned significance of the conflict.

0= Not applicable, 1= Major, 2= Moderate, 3 = Minor

Other Pharmacy Indicator

This numeric value identifies the originating location of the history claim with which the submitted drug claim conflicts.

0= Not applicable, 1= Your Pharmacy, 3= Other Pharmacy

Previous Date of Fill

This value identifies the last recorded date of service for the active medication in the patient's history file with which the submitted drug claim conflicts.

Quantity of Previous Fill

This value identifies the quantity of the prescription in the patient's history file with which the submitted drug claim conflicts.

Database Indicator

This value identifies the source of DUR screening criteria.

0= Not applicable, 1= First DataBank, 2= Medi-Span, 3= Red Book, 4= Processor Developed, 5= Other

Other Prescriber Indicator

This numeric value identifies the prescriber of the history claim with which the submitted drug claim conflicts.

0= Not applicable, 1= Same Prescriber, 2= Other Prescriber

Free Text Message

This 30-character field provides additional information regarding the DUR conflict.

NC Medicaid will use this the Drug Name and Strength of the conflicting drug, the health condition contraindicated in Drug-Disease conflicts, or the minimum and maximum dose for utilization conflicts.

APPENDIX A

POS/ProDUR Transaction Flows

Flow 1	POS No ProDUR Screening
Flow 2	POS No ProDUR Alerts
Flow 3	POS/ProDUR Alerts Found - Provider Overrides
Flow 4	POS/ProDUR Alerts Found - Provider Cancels
Flow 5	POS/ProDUR Alerts Found - Provider Cancels and Resubmits
Flow 5a	POS/ProDUR Alerts Found - Provider Changes Rx and Resubmits
Flow 6	POS/ProDUR Alerts Found - No Provider Response
Flow 7	POS Provider Sends Conflict/Intervention/Outcome Codes on a New Claim; DUR Conflicts DD, TD, ER
Flow 7a	POS Provider Sends Conflict/Intervention/Outcome Codes on a New Claim; DUR Conflicts HD, LD, LR
Flow 8	POS Reversal Transaction - Transaction is Accepted
Flow 9	POS Reversal Transaction - Edit Errors are Found
Flow 10	POS Reversal Transaction - Original Claim Not Found on File

1 POS/ProDUR Transaction Flow

No ProDUR Screening

Pharmacist		Processor
Submits a claim	→	POS receives claim; POS finds edit errors; ProDUR screening bypassed
Receives reject response Realizes there will be no Medical Assistance reimbursement for providing service	←	"Rejected" response is sent; Response status = "R"

2 POS/ProDUR Transaction Flow

No ProDUR Alerts

Pharmacist		Processor
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; No ProDUR screen(s) fail
Receives payable response	←	"Payable" response is sent; Response status = "P"

3 POS/ProDUR Transaction Flow

ProDUR Alerts Found-Provider Overrides

Pharmacist		**Processor**
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s); Response status = "R"
Resolves DUR conflict(s); Selects **one** conflict code		
Resubmits claim with 6-character conflict/intervention/ outcome code indicating override	→	POS receives claim with conflict/intervention/outcome codes; POS matches claim to suspended claim; ProDUR screens overridden
Receives payable response	←	"Payable" response sent Response status = "P"

4 POS/ProDUR Transaction Flow

ProDUR Alerts Found-Provider Cancels

Pharmacist		Processor
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim; Provider must respond to override the alert or cancel the claim
Receives rejected response Realizes there will be no Medical Assistance reimbursement for providing service	←	"Rejected" response is sent with conflict code(s); Response status = "R"
Selects **one** conflict code		
Sends informational transaction with 6-character conflict/intervention/outcome code indicating cancellation	→	POS receives transaction with conflict/intervention/outcome codes; POS matches claim to suspended claim
Receives acknowledgment	←	Acknowledgment of cancellation is sent; Response status = "P" Payable Amount = $0

5 POS/ProDUR Transaction Flow

ProDUR Alerts Found-Provider Cancels & Resubmits

Pharmacist		Processor
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim; Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s); Response status = "R"
Changes claim's drug, quantity, and/or days supply; Cancels original claim		
Sends informational transaction with 6-character conflict/ intervention/outcome code indicating cancel	→	POS receives conflict/ intervention/outcome codes; POS matches claim to suspended claim
Receives acknowledgment	←	Acknowledgment of cancellation is sent; Response status = "P" Payable Amount = $0
Submits new claim with changed drug, quantity and/or days supply		

5a POS/ProDUR Transaction Flow

ProDUR Alerts Found-Provider Changes Rx & Resubmits

Pharmacist		Processor
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim; Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s); Response status = "R"
Changes claim's drug, quantity, and/or days supply; Resubmits with 6-character conflict/intervention/outcome code indicating override	→	POS receives and matches claim to suspended claim; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim; Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s); Response status = "R"
Resolves DUR conflict(s) Selects **one** conflict code		

Resubmits claim with 6-character conflict/intervention/ outcome code indicating override → POS receives and matches claim to suspended claim; ProDUR screens overridden

Receives payable response ← "Payable" response sent Response status = "P"

OR

Sends informational transaction with 6-character conflict/intervention/ outcome code indicating cancel → POS receives and matches to suspended claim

Receives acknowledgment ← Acknowledgment of cancellation is sent; Response status = "P" Payable Amount = $0

6 POS/ProDUR Transaction Flow

ProDUR Alerts Found-No Provider Response

Pharmacist		**Processor**
Submits a claim	→	POS receives claim; POS finds no edit errors; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s); Response status = "R"
No return response		Claim remains suspended, subsequently canceled by system

7 POS/ProDUR Transaction Flow

Provider Sends C/I/O Codes on a New Claim

DUR CONFLICT CODES: DD, TD, ER

Pharmacist

Submits a claim with conflict, intervention and outcome codes for DUR conflicts: DD, TD, ER

Processor

POS receives claim with conflict, intervention and outcome codes;
POS does not find a suspended claim that matches the new claim;
The conflict, intervention and outcome codes are ignored;
ProDUR screening performed;
Claim is treated as a first-time submission, in which case any of the other flows may occur

7a POS/ProDUR Transaction Flow

Provider Sends C/I/O Codes on a New Claim

DUR CONFLICT CODES: HD, LD, LR

Pharmacist		Processor
Submits a claim with conflict, intervention and outcome codes for DUR conflicts: HD, LD, LR	→	POS receives claim with conflict, intervention and outcome codes; POS does not find a suspended claim that matches the new claim; The conflict, intervention and outcome codes are recorded; ProDUR screening performed; ProDUR screen(s) fail; POS suspends claim; Provider must respond to override the alert or cancel the claim
Receives rejected response	←	"Rejected" response is sent with conflict code(s) **except** those on original claim; Response status = "R"
Resolves DUR conflict(s); Selects **one** conflict code		
Resubmits claim with 6-character conflict/intervention/ outcome code indicating override	→	POS receives claim with conflict/intervention/outcome codes; POS matches claim to suspended claim; ProDUR screens overridden
OR		
Sends informational transaction with 6-character conflict/intervention/ outcome codes indicating cancel	→	POS receives and matches claim to suspended claim;
Receives acknowledgment	←	Acknowledgment of cancellation is sent; Response status = "P" Payable Amount = $0

8 POS/ProDUR Transaction Flow

Accepted Reversal Transaction

Pharmacist		Processor
Submits a reversal	→	POS receives reversal; POS finds no edit errors; POS finds original claim in paid status; POS reverses claim
Receives acknowledgment	←	Acknowledgment of reversal is sent Response status = "A"

9 POS/ProDUR Transaction Flow

Rejected Reversal Transaction

Pharmacist		Processor
Submits a reversal	→	POS receives reversal; POS finds edit errors
Receives rejected response	←	Rejected response is sent Response status = "R"

10 POS/ProDUR Transaction Flow

Reversal Transaction - Original Claim Not on File

Pharmacist		**Processor**
Submits a reversal	→	POS receives reversal; POS finds no edit errors; Original claim is not found
Receives rejected response	←	Rejected response is sent Response status = "R"

Drug-Drug Interaction Example

Drug-Drug Interaction	
Drug 1 :	Amiodarone
Drug 2 :	Warfarin
Severity Level:	1

Recipient Claim History		
Drug 1:	Date of Service	Days Supply
Amiodarone 200mg	08/01/96	30

Incoming Claim Information	
Drug 2:	Date of Service
Warfarin 5mg	09/03/96

Processing

Evaluate Recipient History

Each of the recipient's history claims are evaluated to determine the date on which the drug is no longer active in the recipient's system. The formula used to determine the active end date is as follows:

1. Multiply the Days Supply by the Days Supply Percentage for Drug-Drug (usually 115%)
2. Add the number of days to the Date of Service

Using this formula, Drug 1 is active until 09/05/96 (30 * 1.15 = 35 Days; 08/01/96 plus 35 days = 09/05/96). The drug is considered active if the calculated end date is greater than the incoming drug's date of service.

Determine Drug-Drug Interaction

The Drug-Drug precautions are searched using the active history drug as Drug 1 and the incoming claim drug as Drug 2. If a match is found, an alert is issued.

Results

This drug combination will cause a severity level 1 Drug-Drug alert (DD) to be returned.

Over Utilization/Early Refill Example

Recipient Claim History

Drug	Date of Service	Days Supply
Propranolol 40mg tablet	08/01/96	30

Incoming Claim Information

Drug	Date of Service
Propranolol 40mg tablet	08/22/96

Processing

Evaluate Recipient History

The recipient's history is searched for a drug matching the incoming claim. If a match is found, the following formula is applied to the history claim to determine if the refill is too soon:

1. Multiply the Days Supply by the Days Supply Percentage for Over Utilization (usually 75%)
2. Add the number of days to the Date of Service

For this example, the calculated date is 08/24/96. (30 * 0.75 = 23; 08/01/96 plus 23 days = 08/24/96). The refill is considered early if the calculated date is greater than the incoming claim's date of service.

Results

An Over Utilization alert (ER) will be returned since the calculated date, 08/24/96, is greater than the date of service, 08/22/96.

Under Utilization/Late Refill Example

Maintenance Drug

Theophylline 300mg tablet

Recipient Claim History

Drug	Date of Service	Days Supply
Theophylline 300mg tablet	07/01/96	30

Incoming Claim Information

Drug	Date of Service
Theophylline 300mg tablet	08/15/96

Processing

NOTE: Processing for this screening is for maintenance drugs only.

Evaluate Recipient History

The recipient's history is searched for a drug matching the incoming claim. If a match is found, the following formula is applied to the history claim to determine if the refill is late:

1. Multiply the Days Supply by the Days Supply Percentage for Under Utilization (usually 125%)
2. Add the number of days to the Date of Service

For this example, the calculated date is 08/08/96 (30 * 1.25 = 38 Days; 07/01/96 plus 38 days = 08/08/96). The refill is considered late if calculated date is less than the incoming claim's date of service.

Results

An Under Utilization alert (LR) will be returned, since the calculated date, 08/08/96, is less than the date of service, 08/15/96.

Low Dose/High Dose Example

Low Dose/High Dose Precautions

Drug	Minimum Dose	Maximum Dose
Cimetidine 400mg tablet	1 tablet	6 tablets
Captopril 50mg tablet	1 tablet	9 tablets

Incoming Claim Information

Drug	Quantity	Days Supply
1. Cimetidine 400mg tablet	30 tablets	60
2. Captopril 50mg tablet	360 tablets	30

Processing

The Dose is calculated by dividing the Quantity by Days Supply. The Dose is then compared to the Low Dose/ High Dose criteria.

A low dose alert will be returned if the calculated Dose is less than the minimum dose for the drug.

A high dose alert will be returned if the calculated Dose is greater than the maximum dose for the drug.

For claim 1 the Dose is 0.5 tablet per day (30 divided by 60).
For claim 2 the Dose is 12 tablets per day (360 divided by 30).

Results

Claim 1 will return a low dose alert (LD) since 0.5 is less than the minimum dose of 1 tablet per day.

Claim 2 will return a high dose alert (HD) since 12 is greater than the maximum dose of 9 tablets per day.

Therapeutic Duplication Example

Therapeutic Duplication

Drug 1 : Diazepam 10mg oral tablet; Therapeutic Class H2F
Drug 2 : Triazolam 0.125mg oral tablet, Therapeutic Class H2F
Drug 3: Triamcinolone topical cream, Therapeutic Class P5C
Drug 4: Flunisolide topical ointment, Therapeutic Class P5C

Recipient Claim History

	Date of Service	Days Supply
Drug 1: Diazepam 10mg tablet	08/01/96	30
Drug 3: Triamcinolone topical cream	08/15/96	5

Incoming Claim Information

	Date of Service
Drug 2: Triazolam 0.125mg tablet	08/15/96
Drug 4: Flunisolide topical ointment	08/18/96

Processing

Evaluate Recipient History

The recipient's history is searched for a drug in the same therapeutic class. If a match is found, the following formula is applied to determine if the prescription is still active:

1. Calculate end Rx date by adding Days Supply to Date of Service.

For this example, the calculated end Rx date for Drug 1 is 08/31/96 (08/01/93 + 30 days = 08/31/96). The calculated date for Drug 3 is 08/20/96 (08/15/96 + 5 days = 08/20/96). If incoming claim's date of service is less than end Rx date, an alert is returned.

Determine Therapeutic Duplication

Two drugs are considered therapeutic duplicates under the following conditions:
1. The drugs belong to the same Therapeutic Class AND both drugs are systemic
2. The drugs belong to the same Therapeutic Class, the incoming drug is not systemic, AND both drugs have the same route of administration.

Results

For Drugs 1 and 2, the history drug and the incoming claim drug belong to the same Therapeutic Class, both drugs are systemic and the incoming claim's date of service is less than the calculated end Rx date; therefore, a Therapeutic Duplication alert (TD) is returned.

For Drugs 3 and 4, the history drug and the incoming claim drug belong to the same Therapeutic Class, the incoming claim drug is NOT systemic but matches route of administration, and the incoming claim's date of service is less than the calculated end Rx date; therefore, a Therapeutic Duplication alert (TD) is returned.